[H.A.S.C. No. 107–39]

HEALTH CARE SHARING BY THE DEPARTMENT OF DEFENSE AND THE DEPARTMENT OF VETERANS AFFAIRS

HEARING

BEFORE THE

HEALTH SUBCOMMITTEE

OF THE

COMMITTEE ON VETERANS' AFFAIRS

AND THE

MILITARY PERSONNEL SUBCOMMITTEE

OF THE

COMMITTEE ON ARMED SERVICES
HOUSE OF REPRESENTATIVES

ONE HUNDRED SEVENTH CONGRESS

SECOND SESSION

HEARING HELD
MARCH 7, 2002

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HEALTH CARE SHARING BY THE DEPARTMENT OF DEFENSE AND THE DEPARTMENT OF VETERANS AFFAIRS

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ARMED SERVICES,
MILITARY PERSONNEL SUBCOMMITTEE,
COMMITTEE ON VETERANS' AFFAIRS,
HEALTH SUBCOMMITTEE,
Washington, DC, Thursday, March 7, 2002.

The subcommittees met, pursuant to call, at 11 a.m., in room 2118, Rayburn House Office Building, Hon. John McHugh (chairman of the Military Personnel subcommittee) presiding.

OPENING STATEMENT OF HON. JOHN MCHUGH, A REPRESENTATIVE FROM NEW YORK, CHAIRMAN, MILITARY PESONNEL SUBCOMMITTEE

Mr. MCHUGH. (Presiding.) Good morning. Welcome. I have to say, Chairman Moran, that from my experience this hearing has definitely produced a much better looking crowd. We have to do this more often.

But beyond the crowd, I would say it is obvious today's hearing is very different from others, certainly in my experience as the chair of the Military Personnel Subcommittee, in that it obviously brings together two subcommittees from different House committees for a common purpose and a common cause.

And that purpose, again, obviously, is to provide a basis for deciding what joint legislative action, if any, is needed in the short term to facilitate improved, mutually beneficial health care sharing between the Department of Defense (DOD) and the Department of Veterans Affairs (VA).

The fact that the two subcommittees have joined in a common purpose should be a strong signal that many of us are not satisfied with the current extent of sharing, and, again, many have serious questions regarding the commitment of both Departments to remove the often-identified barriers that exist to improve sharing.

Why, for example, 20 years after enactment of the broad authority to enable DOD-VA sharing to go forward, do the two Departments and the health care beneficiaries they serve still find themselves with sharing initiatives whose success is largely related to the ability, perseverance and personality of local VA and DOD health care leaders willing to fight their way through the obstacles that block their success?

Why do they find themselves with sharing initiatives whose value constitutes, in relative terms, a very small, even some would

say, minuscule amount compared to the $35 billion in annual combined health care budgets of both Departments?

Why do they find themselves with DOD and VA health care delivery, workload, beneficiary information, management, cost accounting and financial information systems that remain, to a very large extent, incompatible and unable to communicate, despite numerous studies over the years pointing out these inadequacies?

And why, 20 years later, do the two Departments seem to be without either a common purpose or a joint vision for what sharing should achieve and without a metric or means for how sharing success should be measured?

I am very heartened to hear that not only has the Administration made closer DOD and VA coordination a major goal, but also that senior leaders in both Departments recently announced their reinvigorated efforts to improve sharing.

We are here this morning and fully willing to assist the Administration and both Departments to sustain that newly found vigor. However, I know enough about previous statements regarding renewed commitments to DOD-VA sharing to understand that sustained joint action did not always follow. Given that history, I believe that many of the members on these two subcommittees are understandably skeptical about the prospects for improved sharing if the initiative for the improvement is left totally and entirely to the discretion of the two Departments.

However, at least in my mind, before either subcommittee takes directive legislative action, or we jointly take action, I think it would be very useful, and in fact, we need better understanding of a range of issues. And that is certainly why I personally look forward to the testimony of all our witnesses today.

Before I recognize the first witness, I would like to make just a few administrative remarks because of the rather unusual structure here this morning, because this is, as I mentioned, a joint hearing between the two committees, Chairman Moran, Mr. Filner and Mr. Snyder and I and the counsels have agreed on guidelines that we hope will allow the hearing to proceed in as orderly a fashion as possible and allow each member attending today the chance to get their questions before the witnesses.

Our respective committee staffs have met with the members' legislative assistants earlier this week to discuss these guidelines and to provide all of you on the joint panel today with your background memoranda.

We have 11 witnesses and 3 panels. The key is that we need to give each witness the opportunity to present his or her testimony and each member an opportunity to question the witnesses. Therefore, we have agreed, unlike the normal practice on the Military Personnel Subcommittee, to impose the 5-minute rule on witnesses' opening statements and on members. I know that poses some difficulties, but given the size of today's hearing, I hope everyone can accommodate us in that regard.

I would respectfully remind the witnesses that we desire that you summarize, to the greatest extent possible, the high points of your written testimony and assure you that your written comments and statements will be made part of the hearing record.

At the end of the government panel, the second panel, I will yield the gavel to Congressman Moran, my friend, the gentleman from Kansas, who is chairman of the Health Subcommittee on the VA Committee, for his opportunity to sit in the big chair here that I am enjoying right now.

Finally, a number of statements have been submitted for inclusion in the record from organizations who understandably wanted to testify but were unable to simply because of our time limitations and not on any limitation on the value of their submissions. And with that, I would ask unanimous consent that the statements from the Vietnam Veterans of America, the Air Force Sergeants Association and the National Military Family Association be entered into that record. Hearing no objection, that would be so ordered.

Before I introduce the first witness, I will recognize Chairman Moran, followed by Congressman Vic Snyder, the ranking member of the Military Personnel Subcommittee and also a member of the Health Subcommittee. Congressman Filner will then be recognized for his opening statement. And, finally, I would be happy to recognize Representative Evans, who is the ranking Democrat on the Veterans' Affairs Committee for his remarks.

And with that, I would be happy to yield to my co-chairman here this morning, Mr. Moran, for any comments he would like to make.

Mr. MORAN. I thank the chairman, and I am grateful to the gentleman from New York for the opportunity for us to gather today jointly. I think at the moment, Mr. Chairman, we have you outnumbered, particularly with Mr. Snyder being a member of both committees, but we will cooperate with you fully to see that the objectives that you have outlined in your opening statement are accomplished today.

I appreciate the opportunity to join you in this effort, and I think the unprecedented, or nearly unprecedented time that we are together today as a joint effort suggests how important we both take this issue and how both of our committee chairmen and ranking members consider the topics of cooperation, potential cost savings and, even more importantly, the quality of care that our members of the military and our veterans receive is to each of us.

I understand that this issue has a long history, a 20-year effort to share between VA and DOD. It appears to me that virtually unlimited authority was given in Public Law 97–174, and I am here today to learn what the successes and failures have been and what additional legislative or other acts we, as Members of Congress, need to take to see that there are more successes in the future.

I want to have answered for me whether or not the legislation that is currently in place is appropriate or needs to be altered. If it should be changed, how should it be changed? And how should the VA relate to TRICARE?

We have changed in the VA system the delivery of health care and, in addition to trying to strengthen our hospitals across the country, have moved in a way that creates community out-patient clinics in many locations. And I would like to know from our witnesses the effect of providing services in nearly 800 Community Based Outpatient Centers (CBOCs) across the country, and how this will result in the cooperation that can occur between the VA

and the DOD. But with all this new demand, is there room within the system for additional sharing?

I would point out to members of both subcommittees that our staffs have visited VA hospitals and military hospitals over the last few months. Their report has been filed and is available today, and I would recommend it to my colleagues.

It is my pleasure to be here with my full committee chairman, the gentleman from New Jersey, and he has presented what appears to me to be straightforward, common sense, desirable legislation, and I am anxious to see why, at least on first glance, that appears to me to be the case. And what I would like to know is there some reason that my first glance has resulted in a misconception about my chairman's legislation? So I anticipate hearing your comments about what Chairman Christopher Smith is presenting to us today.

And, finally, I and the gentleman from New York, Chairman McHugh, have talked about an issue that our subcommittee is actively engaged in pursuing at the moment, and that is the desire to have additional cooperation between DOD and VA as we deploy men and women around the world, particularly in Enduring Freedom, somewhat with the concept of what did we learn during the Persian Gulf War deployment that we can take to heart and improve the chances that our men and women returning from this operation will return as healthy as possible.

We have had two hearings in our subcommittee on this issue. It seems to me that there is a lot more to be learned and much additional emphasis can be placed on how DOD and VA are working today to protect the men and women who are members of the military at the current time but will soon be veterans when they return home from Operation Enduring Freedom.

So I look forward to the testimony of the witnesses today. I have suggested to Chairman McHugh that we explore the possibility of pursuing these joint hearings on the issue of the health of our men and women in Operation Enduring Freedom further and look forward to working with you in that regard and the consequences of today's hearing and, again, thank Chairman McHugh for the kindness extended to me and to our subcommittee. We are delighted to be with you.

Mr. MCHUGH. I thank the gentleman, and, obviously, his role in this is absolutely essential and I deeply appreciate the Veterans' Affairs Committee and your subcommittee for all of your cooperation and support and hard work and your activities on the committee side.

With that, I would be happy to recognize the ranking member of the Military Personnel Subcommittee, Mr. Snyder.

Dr. SNYDER. Thank you, Mr. Chairman. I have nothing to add to either your message or eloquence or of Chairman Moran's. Just one procedural note: When we had our hearing June 21 of last year, I had submitted some questions for the record to Dr. Garthwaite, and we received those answers I think 3 days ago. That does not seem to me to be a timely response, and while we have—maybe there is some explanation for it, but I just—Mr. McHugh's letter to me is dated March 5.

We have a lot of members who are unable to be here today and we have a compressed schedule. And there may well be other questions for the record, and I hope that we would all agree that eight or 9 months is not a timely response to questions for the record. Thank you.

Mr. MCHUGH. Timely response to have a baby but not for the record. I agree. I thank the gentleman for that.

Congressman Filner has not been able to join us as yet, so we will then move to the ranking member on the Veterans' Affairs Committee, Congressman Evans.

Mr. EVANS. Thank you, Mr. Chairman. I think all of us are concerned about the status of VA–DOD sharing, and that comes even in terms of helping homeless veterans. The National Guard units will give blankets and things of that nature. So we appreciate you holding the hearing. We believe that there is much to be done, but this is what this hearing is about. So I yield back the balance of my time.

Mr. MCHUGH. Thank the gentleman. Thank him as well for his long hard work on this issue. We now recognize the first panel, a man of such stature he is his own panel.

[Laughter.]

Not only for his great work and leadership on the Veterans' Affairs Committee, which all of us are grateful, and not only for this efforts in this regard, and I would surmise the main topic of his conversation this morning, his bill, H.R. 2667, that is designed in total to achieve the purpose for which we are meeting here this morning, but also because he is a heck of an infielder for the baseball team. So I appreciate him on all levels.

Chairman Smith, welcome. We are anxiously awaiting your testimony, and with that, I would turn the floor over to you, sir.

STATEMENT OF HON. CHRISTOPHER H. SMITH, A REPRESENTATIVE FROM THE STATE OF NEW JERSEY, CHAIRMAN OF THE COMMITTEE ON VETERANS' AFFAIRS

Mr. SMITH. Thank you, Chairman McHugh and Chairman Moran. I am very grateful to have been invited here today to speak to the issue of joint VA–DOD sharing. It is an issue that has been around for decades, literally. It is a largely unrealized gem that needs to be, I think, more aggressively utilized by the Department of Defense and by the Veterans Administration.

And just to say a couple of things, earlier today Lane Evans and I presented our budget views and estimates on behalf of our committee after working weeks, literally weeks, to crunch the numbers, to read and analyze the budget submission by the Administration. And the bottom line is that there will be about 700,000—last year's budget estimate for new unique patients grows by about 700,000 veterans, with another 75,000 non-veterans, for a total of 775,000 new VA patients.

And the budget submission, with all due respect,—that came to us from the Administration—does not meet those needs. And it is all about how do we do a needs-based budget and meet the needs of our veterans in the area of health care while continuing to provide and always hopefully improving a world class system.

The sharing agreement, passed in the 97th Congress, does provide a blueprint. It is not a panacea but does provide, we believe, at least part of a fix to try to provide this health care. We provided, both Lane and I, a $3.2 billion year-over-year increase to the medical care budget. It is going to be a tough road, a tough road to get that money enacted finally by the Budget Committee and then by the Appropriations Committee. Meanwhile, we need to find innovative ways to make it possible for our veterans and our men and women in uniform to get the best possible health care.

If we are to continue providing quality health care for all of those who need it, we must make the best use of those resources, Mr. Chairman, that are currently available. Inefficiencies and duplication not only waste taxpayer dollars, they shortchange military personnel, retirees and veterans seeking health care.

This year, the Departments of Veterans Affairs and Defense will spend between $35 and $40 billion, as you pointed out in your opening comments, combined on health care for current or former military personnel and their families. Yet despite this enormous sum, there is still not enough to meet their health care needs. The Federal Government must find ways, innovative ways, to maximize efficiency and minimize unnecessary, duplicative services that drain dollars from their primary purpose—providing timely, quality health care to present and former service personnel and their families.

I strongly believe that the Federal Government must aggressively seek to increase resource sharing between these two massive health care systems, whenever and wherever feasible. Although Congress has made efforts in the past to promote specific sharing, the results have been modest at best.

As you know, Mr. Chairman, and I know you and your staff, as well as Mr. Moran and the ranking member have looked at this, in Albuquerque, New Mexico, there is a VA-Air Force partnership between the VA Medical Center and Kirkland Air Force Base Hospital that provides admitting privileges to Air Force physicians. The relationship between the VA and the Air Force at these facilities is a good beginning to sharing.

However, despite promising sharing relationships between the two, there remains many untapped areas where new efficiencies could be achieved in Albuquerque. For example, the Air Force and the VA needlessly maintain separate dental clinics, central dental laboratory functions and separate supply chains. Also, the Air Force continues to maintain a management presence as though it were still operating in an independent hospital facility, even though most of its activities duplicate those of the VA.

Some facilities that are close neighbors—essentially co-located facilities—could become joint facilities, thereby almost certainly reducing the administrative costs as well as staffing needs. With such savings, additional resources could be invested in patient treatment and technological improvements.

For example, at the San Diego VA Medical Center, the fiscal year 2001 budget is $202 million, and at the Balboa Naval Medical Center, the fiscal year budget is $338 million. Although these facilities are only a few miles apart, no clinical sharing occurs between the

two. Does anyone doubt that money could be saved by reducing duplication of services, and realizing the synergies of sharing?

For too many neighboring VA and DOD facilities, separate management and operations are the only way they conceive of doing business—that is the way we always did it, let's just keep doing it that way—even when another Federal medical facility, also supported by public dollars, is just a mile or two or a stone's throw away. I am convinced that this separateness is the result, at least in part, of deeply ingrained habits, entrenched organizational cultures and long-standing turf battles.

Perhaps the most illustrative example of the failure to pursue sharing agreements that we have seen in the committee is in Charleston, South Carolina, home to the Naval Hospital, Charleston and the Ralph H. Johnson VA Medical Center. During a recent visit by the Veterans' Affairs Committee staff, the Naval Hospital's director, in the course of discussing the issue of resource sharing, also talked of the difficulty they experienced in recruiting and retaining pharmacy technicians to meet the demand for approximately 500 mail-out prescriptions every day.

What the Navy did not see is literally right across the street: a VA Consolidated Mail Outpatient Pharmacy facility, one of eight nationwide, which produces 52,000 mail-out prescriptions daily for eligible veterans. When our committee staff and the Navy personnel met with the director of the VA facility, they told us that they would have little problem whatsoever in fulfilling an additional 500 prescriptions, which would increase the workload by less than 1 percent of their daily volume.

That was last April. Today, amazingly, almost 1 year later, there has been no change. The new executive staff at the Naval Hospital seems unaware of our staff's visit, or of the possibility of utilizing the VA pharmaceutical facility. In other words, nothing has changed.

These are just a couple of examples, and hopefully this committee, and you will do your own independent analysis as well, will realize that there are many more egregious examples that just beg rectification.

As I think you know, Mr. Chairman, as you pointed out, last year I introduced H.R. 2667, the Department of Defense-Department of Veterans Affairs Health Resources Improvement Act of 2001. This legislation takes another step toward fulfillment of the goals set out almost 20 years ago by Public Law 97–174, the Sharing Act.

Our legislation would establish five health care sharing demonstration projects in five qualifying sites across the country. The purpose of the demonstration projects would be to reward those who are not daunted by the current obstacles that prevent sharing where it is clearly possible.

H.R. 2667 would, to the extent feasible, require a unified management system to be adopted in the five demonstrationsites to the extent feasible. A unified system would look at ways to eliminate differences between the budget, health care provider assignment, and medical information systems. At the same time, the two Departments' information systems are still incompatible—at the present time, I mean—and so this legislation would also encourage greater software compatibility. By making such systems commu-

nicate better, we can better ensure continuity of care, equality of access, uniform quality of service and a seamless transmission of data.

In addition, the demonstration projects would provide the enhancement of graduate medical educational programs at the five sites. This will create a great opportunity for health care profession students by giving them a combined exposure that has not been available to them before. It would also bring better awareness and understanding of differences in the two beneficiary populations for new and experienced health care professionals alike. We believe this is a good framework for moving this process along.

And let me just conclude, Mr. Chairman, and I thank you for this time. When I first got elected in 1980, one of the first bills our committee, under the leadership of Sonny Montgomery considered was the sharing legislation. It came out of the blocks with all kinds of promise. Even then we were talking about budget shortfalls in both the VA as well as in the DOD budget.

I went to one of my bases, Fort Dix, New Jersey. We have three contiguous military bases, and until recently, you almost needed a passport to go from one to the other. That is how they did not share back in the 1980's. Lakehurst, McGuire and Fort Dix.

At Walson Hospital, I observed that there was one floor after another underutilized and seemed to me since we had a growing veterans population, particularly an older, aging population, that an outpatient clinic, which was the movement of the VA then and continues to be, would be a place to put it, right there at Fort Dix.

We got all of the Xs in the box, Mr. Chairman. The Department of Defense agreed to it, the Surgeon General of the Department of Defense, the Administrator of VA, right on down the line. Then at the very last moment, the commanding officer reversed himself 180 degrees and said, "I think I might need that space." Well, he took it back.

Ten years later we got an outpatient clinic, we built one, in Brick, New Jersey. It took 10 years. And it is overused. We now have another one that will be going into Monmouth County very shortly because of the excess numbers of patient visits.

Opportunity lost. We have had 20 years, Mr. Chairman, of opportunity lost where we can again realize the synergies of utilizing excess capacity and realizing, as we would have done at Fort Dix. And now we do have something there at Fort Dix, but it is a long time, 20 years later.

So I offer that up to you. There has been that reluctance over the years. It is institutional. You know, for whatever reason, the cultures need to be, where they can, be merged to get the greatest bang for the buck for the taxpayer and for the men and women in uniform and the veterans. Thank you, Mr. Chairman.

[The prepared statement of Mr. Smith can be found in the Appendix on page 56.]

Mr. MCHUGH. I thank you, Chairman Smith. And, again, I want to compliment you on the very hard work and very comprehensive work that you put forward with respect to this bill and to the issue in general.

I want to give you a chance to—first of all, let me preface and say that we have had a lot of opportunity to look at your bill. There

is a lot in it that, at least to me personally, makes sense. As happens in any piece of legislation, you try to talk to folks who have either an administrative interest or an interest, in this case, with respect to patients and those who would utilize the facilities.

And one of the things we heard from some of the outside groups is that they felt your bill took an integration approach. We get hung up on semantics far too often, and what they supported was rather a sharing. I think the concern is probably predicated upon the largely different beneficiary populations and the specific needs, and they were worried that a true integration might diminish, erode the quality of care to some of those specific needs.

Would you want to comment just briefly on those semantics and what you are attempting to do? And you are trying to seek a full seamless integration or is that just a turn of phrase?

Mr. SMITH. Frankly, I think very often words can be used to deter reform and change, and we all, every one of us, sometimes are reluctant to change from time to time if that is not the way we have done it before. And the fear of the unknown can lead to roadblocks.

But we are talking about partnerships. I would not expect any diminution of services to current men and women in uniform; matter of fact, there could be an enhanced provision of care for them as a result of this, especially where technology—you know, MRIs and the like are very expensive, and where we can share facilities and get greater utilization of technology, we ought to be doing it.

Many states, including my own, follow the certificate— of—need format. It seems to me that in the scarce dollars that we all have in both budgets, DOD as well as in the VA, there are services that are not rendered simply because there is insufficient money.

We are looking to, again, realize a partnership, and integration may be a word that is thrown out from time to time, but partnership is what we are looking for, and I would not expect either the veterans, because they too have expressed some concern that the core mission, especially as it relates to service-connected disabled veterans, might be diminished as a result of the DOD partnership.

And I think the admonishment, at least from our point of view, is that we are not looking to do anything of the kind. We want reasonable men and women in the field, as well as here in Washington administering the programs, to do what is best for both.

And, again, as I mentioned about my own VA outpatient clinic, you know, Walson Hospital remained—and I did not finish the story—remained unused. Years later I would go back to the hospital and say, "The floors still are unused. What is the problem here?" And I think the reluctance to change is, again, part of the human condition.

And there are two different populations served, by and large, although, you know, with the all-volunteer Army, we do have some of that spectrum changing a little bit as well. We do have older men and women in uniform, we do not have a draft. So I do think that this is all about partnership, it is not about somehow merging the two.

And the idea of the seamless transition, which has been highlighted in previous reports to Congress, including the report chaired by now (VA) Secretary Principi, talked about that seamless

transition. Why is it that we do not have the data on certain medical personnel records because the interface has not occurred and the pass-off of the baton is not so easily made from DOD to the VA. It would be nice if we had from sign-up to VA perhaps a provision of care that we know who this patient is.

So I see nothing but positives coming out of it if it is done smartly. And I would hope, given all the eyes and ears that are looking at it and the distinguished people that will be testifying after me, once the political decision has been made to do it and that the roadblocks are not done at some mid-level to say it cannot be done, it can be done, and it should be done, and that does not mean 5 years from now we will realize savings that get plowed right back into both systems.

Mr. MCHUGH. Thank you for that clarification. I still have a green light, so I want to ask one more question.

There are concerns, understandably, any time Congress starts writing cookie cutter prescriptions for a system that has needs and vagaries that are found throughout different regions. VA has their Veterans Integrated Service Network (VISNs), we have the TRICARE service areas, et cetera.

Am I correct in assuming that the intent that is embodied in your bill of five demonstration projects is an attempt to find some common theme there that where it is appropriate it can be dictated from a national level, and to also identify areas based on regionalism where cooperation—partnership is used, the word—can be implemented? I do not see in your bill an attempt to do that cookie cutter prescription. Am I reading the bill correctly?

Mr. SMITH. No, we are leaving, Mr. Chairman, national flexibility to the Department of Defense and to the Department of Veterans Affairs to decide which of those projects will get funded and be rewarded by way of funding. We are looking that this be an incubator to prove or disprove, to figure out what can be done, how far can the envelope be pushed without in any way diminishing any of the core provisions of care. So we are not saying, "This is where you put it." This is not a military construction line item. This is saying, this is—we are providing enhancements. And we do use the word where feasible.

Again, if there is a political way, if there is a push, having this hearing, both you and Mr. Moran and your ranking members, I believe, helped move the process along, because it sharpens the mind when our friends in the executive branch need to come up here and say, "What are you doing?"

One of the most under heralded parts of this job, as we all know, is oversight, making sure that once we pass a law, even where it said, "shall," 2 years later we find out that "shall" did not mean shall. But here we are again just trying to move this process along and act as an incubator for reform.

Mr. MCHUGH. I thank the gentleman. Yield to Chairman Moran.

Mr. MORAN. Thank you, Mr. Chairman. I would only commend my colleague and friend from New Jersey for his commitment, long-term commitment, in listening to his testimony today and look forward to working with him and you, Chairman McHugh, on this topic. My senior staff has advised me that any questions of the full committee chairman are outside the political correctness, and so I

will defer—I will catch you in the hallway, Mr. Chairman. Thank you.

[Laughter.]

Mr. MCHUGH. Thank you. Dr. Snyder.

Dr. SNYDER. Thank you, Mr. Chairman.

And thank you, Mr. Chairman, for your testimony. I was struck, Mr. Chairman, by your very strong statements about the culture of protection that permeates both bodies. You used the phrase, "reluctance to change" "turf battles." I am reminded of the old saying, "Does a fish feel the wet?" You know, if you talk to a fish, and I do not do this very often, but they do not feel wet, they are not aware that they are in the water. That is just where they are at all the time, and I think what you are trying to do with this legislation is say we want the culture to be changed.

Now, we have a lot of good people sitting here today, a lot of good people in the system, and they are probably thinking, "Wait a minute. What is this culture, what is this protection you are talking about, this resistance to change? We change all the time. We are good people." And they are all good people.

But the only comment I would make is I think legislation is just going to be one part of this, but there is going to have to be these, as you said, oversight hearings, ongoing discussions, the topics need to come up at confirmation hearings as years gone by so that at some point all us fish together actually feel the wet and recognize that we have to change that culture that we are in. Thank you.

Mr. MCHUGH. Thank the gentleman.

Mr. EVANS. No questions.

Mr. MCHUGH. Mr. Ryun? My goodness, we are doing well. Mr. Rodriguez?

Mr. RODRIGUEZ. Thank you very much, Mr. Chairman. I know better than to ask any serious questions of my chairman, so let me just say that there is no doubt that we want to, at least, the purpose of this hearing is to gather things that we need to do and encourage and see how we might be able to come up with other things, as well as be able to come up with some suggestions and maybe some ideas as to how we can enhance services.

I am going to have to be taking off to another meeting, but I want to be able to, at least to the other panels, be able to provide some questions, because one of the questions that I have is as we move over to base closure process, how does that impact on VA and DOD services?

Second, in what ways can we—you know, we recognize that there are certain areas that are lacking in services—how we might be able to enhance those services in those areas by these efforts in terms of coordination. And, of course, you have already filed legislation, but maybe the staff might also have some other guidelines as to other pieces of legislation and other recommendations. Legislatively I would like to hear from that and from the next panels that come up.

And, unfortunately, I came up at a time when I was just getting ready to leave to go to my next meeting, but I will be looking at your legislation. Because I do feel that there are some areas where we can coordinate. I know that in some areas they are not getting

third party reimbursements the way they should, both in the Department of Defense and I have looked at some language there in the past, but we need to see how we might be able to improve on that, especially in light of TRICARE, how the services can be provided both for the veteran at the DOD and for the retiree at the VA and how that might come about in a more smoother manner.

In addition, I know the VA is looking at some research areas where the DOD could also participate. And I know there is some coordination already going on, so I wanted to—and, unfortunately, I am going to have to be taking off, but I want to thank you for your testimony.

Mr. SMITH. Thank the gentleman from Texas. If I could respond just briefly because you raise an interesting question. Our hope is, and this question perhaps goes to the next couple of panels, that as the Capitol Asset Realignment for Enhanced Services (CARES), process goes forward—just as the Base Realignment and Closure (BRAC), and there may be, as we know, another (BRAC) in 2005—but as the CARES process goes forward, there ought to be a lot of thought given as to if there is going to be a veterans facility mothballed, that is there some other usage within the DOD? Can it be salvaged by some addition utilization?

One of the things we have already asked, and I have asked Secretary Principi, is to factor both this in as well as the homeland security issue, because we know the VA, its fourth mission of dealing with emergency preparedness and potential disasters, we have to have capacity to realize that as well.

So as we have our own BRAC within the VA, which is known as CARES, certainly this ought to be part of that so we have the big picture at all times and we do not end up doing something and say, "Oh, if we only had thought that through a little further, that facility would have stayed open or that outpatient clinic." So I appreciate you raising that.

Mr. MCHUGH. Ms. Davis?

Mrs. DAVIS. Thank you, Mr. Chairman, and I am very sorry that I missed my chairman's remarks earlier, but I understand that you did not mention San Diego, and I look forward to working with you on that. We have a fine example of good, strong Administration in both places, but I think that there is a lot that still can be done. And I have visited those facilities, and I ask a lot of those same questions too.

So it might be that we can look at that and see what kind of incremental changes, if not major, comprehensive changes, can be made, but also working with the culture and what it takes to get some of that sharing done. So I will be happy to do that with you. Thank you.

Mr. MCHUGH. Thanks, Ms. Davis.

Mr. MCHUGH. Mr. Wilson? Mr. Boozman.

Mr. BOOZMAN. I would just like to say that I appreciate all the hard work that Chairman Smith has put into this effort. You know, this seems to be just a common sense thing, and hopefully all of us can work very hard on this and get it accomplished where it will work together a little bit better.

Mr. MCHUGH. Mr. Miller?

Mr. MILLER. I want to thank Chairmen McHugh and Moran for holding this hearing and certainly enjoyed hearing your comments, Mr. Chairman. And I just want to make a quick statement. I am pleased to serve on both subcommittees, Health and Military Personnel. And my district in northwest Florida is the largest index service network in the Veterans Health Administration (VHA). It is home to over 110,000 veterans who are primarily served by two outpatient clinics.

Both of these clinics are unable to adequately serve the number of veterans seeking care, and I am constantly hearing stories from my veterans and constituents that are required to wait up to 6 months and more for an appointment at the clinic. And, additionally, we do not have a single outpatient or inpatient bed in the Panhandle, and most of my veterans are forced to go to Biloxi, over 4 hours away. And I say this is not only unacceptable, but I think it is a poor allocation of our resources.

And while I have been encouraged by our networks' efforts on a wide variety of sharing ventures with government agencies as well as private-sector health care entities, we can and should do more.

At the most basic level, these two health care systems are in the business of providing quality health care to our nation's active duty military, military retirees and veterans, and especially in light of the finite resources, it is vital that we consistently reexamine, and I think your legislation does that, how we are conducting this business to ensure that we are not only providing the highest quality care in a timely manner but that we are also doing so in the most efficient manner possible.

As our nation's veterans have fulfilled their duty, it is time for us to do our duty to those who have fought for freedom and democracy. And so I thank you for the bill that you have put before us and look forward to working with you on it, Mr. Chairman. And I have questions too, but I will submit them for the record.

Mr. MCHUGH. The record will show that this chairman mispronounced the gentleman's last name from Arkansas. It is not Boozman, it is Boozman, and I apologize. I said Boozman the second time. The only excuse I can think of is my name is John Michael Patrick McHugh, and it is getting close to St. Patrick's Day.

[Laughter.]

Other than that I have no excuse, and I apologize to the gentleman. Mr. Miller? Mr. Simmons?

Mr. SIMMONS. Thank you, Mr. Chairman, and I thank Chairman Smith for his testimony. And I could not agree more with what he is saying.

I served for over 30 years active and Reserve in the U.S. Army, and for many years as an Army Reservist, we talked about the issue of seamlessness, that when a Reservist is activated or when a member of the Guard is activated, they will move seamlessly into the active component and into the mission that is assigned there.

And for all of the talk of seamlessness, it has only really been in the last six or eight years that we have really accomplished that and that you really cannot see the difference, in training, in physical fitness and in qualifications of that Reservist as compared to that active component person.

And if you look at what our men and women are doing in Afghanistan and elsewhere around the world today, we have integrated the Reserves with the active component, and that has increased the capabilities of our fighting forces dramatically, and I think it is a plus, and it is a positive.

But we continue to confront that problem. I think when it comes to the provision of health care to veterans that somehow when you are on active duty you are entitled to better health care than when you retire, when you go off of active duty and then you go into the VA system.

And I have encountered that in my own district in eastern Connecticut where we have a Navy base that has a Navy hospital. And we have tried for years to get the Navy base and the Navy hospital to provide services for the VA. But when it finally came to locating a VA community clinic in the New London area, it did not go to the Navy base and the Navy hospital, it went to the Coast Guard Academy.

Now, the Coast Guard was wonderful in offering their clinic, their small facility for veterans, and the veterans very much appreciate it, and they have been using that facility for 2 years. But for the life of me I do not understand why a Navy base with PX and commissary and all the services, plus a huge hospital up on the hill that is actually cutting back services because the numbers of people on the base are somewhat diminished, did not step in and say, "We will provide the community clinic for the VA because most of the veterans retired in this area are Navy, and most of them have gone through 15, 20 or 30 years of service where at one point or another they have used the facilities of this hospital."

So I think it is a no-brainer, and I just do not understand why there would be resistance for this sort of thing.

And this moves to my third point and my question. In eastern Connecticut, the private sector is not providing as much health care today as they have in the past, due to the failure of HMOs, due to the fact that some employers simply cannot afford to provide health care. And as a consequence, we are discovering that veterans who previously did not avail themselves of the services are doing so now because of need. And I have the impression that that probably is occurring across the country.

And so my question to the chairman is, is that a phenomenon that we are encountering in other states and in other districts? And if so, does not that provide a further reason why we should be focusing on accessing all of the health care resources for our veterans as well as for our active duty personnel?

Mr. SMITH. I think the point is well taken. The HMO or the promise of HMO reform of the 1990's has been largely unrealized, and so many of us have had our own personal experiences with family members, denial of care, the rationing of care, which has led to, at times, catastrophic outcomes. And I do believe many of the veterans are literally voting with their feet.

As I indicated earlier, last year when we got the budget submission from the Administration, they actually had to do, in this year's, an updated estimate for the year 2002, because it had climbed so precipitously. As a matter of fact, the number year over year, as I said at the outset, is about 775,000 more unique patients.

And when you factor that out into the number of patient calls at the outpatient clinics and the other care facilities, it becomes very, very significant in terms of patient load and cost.

So it seems to me, given this rising utilization rate, we need to marry up the resources, and we are trying to do it. As I mentioned at the outset, Mr. Evans and I have worked for months, and our ranking members—Mr. Moran and Mr. Simpson and Mr. Filner—all of us, crunching those numbers and realizing that there is a significant shortfall in the budget submission, and we are looking, and we do not know if we will be successful, but as of today we are recommending $3.2 billion, plus a construction component in addition to that, for the VA. We have to stop doing the VA on the cheap.

We are going to try to find some other more innovative ways of—because you cannot always count on those appropriated dollars or medical care cost collections, third party collections, so where else in the universe do we look? We look at something that is sitting there on a silver platter, sharing, and we are talking about partnership not merger, and saying, what kind of efficiencies can be gleaned from that? It seems to me there are many, and it means higher quality care for those who are opting in.

You know, the VA itself in its submission says about 210,000, the number, and most of them non service-connected veterans and concompensable zero percent service-connected veterans who agree to pay copayments, (Category 7s), will go up to eight million unique patients. My feeling is that number probably is low, because just like they missed it just last year, it was all good will assumed that the utilization would be so much higher. They are voting with their feet.

One last point: Many of those who are walking in—and there is not real hard data on this, but this is anecdotal from my own clinic visits—are the near poor, very often who are sicker and more in need of help coming into the CBOCs and into the outpatient clinics and tertiary care units in need of care. And so shame on us if we do not provide, as you pointed out, that seamlessness of making sure that they are cared for, and I think it is our moral obligation and our duty to do so. This provides part of that piece, if you will.

Mr. SIMMONS. Thank you, Mr. Chairman.

Mr. SMITH. Thank you.

Mr. MCHUGH. Thank you. Mr. Schrock?

Mr. SCHROCK. Thank you, Mr. Chairman. First, Chris, I want to thank you for carrying this legislation, and I can assure you I will support you in any way I can. And I want to identify myself with what my friends, Mr. Miller and Mr. Simmons, said. As a retired naval officer, I certainly understand the need—I was told yesterday by the VA that the 2nd congressional district of Virginia has more veterans and retired military personnel than any district in America, so you can imagine what a huge impact this issue has on our area, and I am going to do everything I can to fight for them.

Mr. Simmons is right. These people that served a career earned it, that is what they were promised, and they need to get it, and they need to get it right away. In our area, we have a magnificent new Navy hospital in Portsmouth that is just the most incredible thing you have ever seen, and they are trying very hard to address some of these needs, but it is hard to address them all.

We have a VA hospital in Hampton, which is north of the tunnel from where I live in Virginia Beach, in the Norfolk area, and I would hope that at some point we could get a VA facility in South Hampton, because tens of thousands of those people live there, and for them to go through the tunnel it is a mental thing. It does not take that long, but sometimes there is gridlock in that tunnel, and if people are sick and need help, they do not need to be making that journey. So I would hope at some point we could do a facility down there. But, again, thank you for this, and I would like to help in any way I can.

Mr. SMITH. Thank you.

Mr. MCHUGH. Mr. Stearns?

Mr. STEARNS. Thank you, Mr. Chairman, and let me also, like my other colleagues, tell Mr. Smith, the chairman of the Veterans' Committee, what a superb job he is doing. I served on that committee now, it is my 14th year in Congress, and Mr. Smith has really worked proactively to try and increase benefits for veterans at the same time to streamline benefits.

And obviously I support this bill, but there are obstacles to sharing, and you and I both know, serving on the Veterans' Affairs Committee, whether it is cultural, which is going to make it difficult for many, if it is corporate or traditional, you also have the incentives sometimes are not working to our benefit. That is going to make it hard. The boundaries between the DOD's TRICARE and the Veterans Integrated Service Network are difficult, not to mention some of the statutory differences.

So I am behind you 100 percent. If anybody can do this, you can. With your enthusiasm and your deep sympathy and appreciation and empathy for the veterans.

I noticed recently that the General Accounting Office (GAO), Director Bascetta highlighted one area in particular in her testimony. She said the data bases in the Department of Defense do not talk to one another, and you would think within the Department of Defense, never mind them talking to Veterans, which we try to do, but within the Department of Defense they would talk together. But she says that is not occurring, and she says just harmonizing the numerous data bases within the Department of Defense seems one area for progress, and then, and then integrating them with the VA of which there are numerous data bases.

So, Mr. Chairman, Mr. Smith can do the job, and I just welcome his enthusiasm and help here and some way we could break through this cultural and corporate and traditional thinking in these two agencies and bring them together, and it might be nice just if the Department of Defense would start sharing their data bases within the Department of Defense. And that is my only comment. Chairman Smith, if you would like to comment on that, that is all I have.

Mr. SMITH. Only to say thank you, but frankly it is a team effort, Mr. Moran has been a talking point on the Health Committee, as you did before as chairman of the Health Subcommittee for VA. Matter of fact, you are the prime sponsor of the Millennium Health Care Act, what continues to be largely unfulfilled, even though the word of the bill said, "shall," not "may," and that has to do with resources. And if we free up resources, there could be more long-

term care beds made available to follow the letter and the spirit of your legislation. And Mr. Moran has been very proactive as chairman of our committee, and I deeply appreciate his leadership.

And Mr. McHugh, this is the kind of thing you leading on DOD's side and Mr. Moran on the VA side we really can get much accomplished and hope we set a further example. Because, again, I assume good will, and I know the people who will follow who really care about these issues. It is a matter of priority, and you know if you say you do not have time for something, you have not stated a fact, you have stated a priority. There are always things crowding out. We need to make this a priority and make the time to make this work. So thank you, Mr. Stearns, but it is a team effort.

Mr. STEARNS. And thank you, Mr. Chairman.

Mr. MCHUGH. Thank the gentleman. We have been joined by a number of members, and I suspect this will occur throughout the afternoon, who serve on either of the two full committees but not on the subcommittee. And, obviously, the interest in this issue extends beyond that. Without objection, I would like to extend to them the courtesy, and with Chairman Smith's forbearance, to allow them to have an opportunity to question if that meets with your approval, Mr. Chairman. And we would start with Mr. Taylor.

Mr. TAYLOR. I would like to thank the both of you, Mr. Chairmen.

Chris, the situation you describe where you have a military hospital and a VA hospital, that is my congressional district, and I am one of the ones who feel like they have not done a good enough job of coordinating. Although to some extent they do coordinate, I think they can always do better.

I was wondering, the Reserve Officers Association a few years ago came up with what I thought was a clever idea: since money is always tight and since every American who works, including folks in the military, pay into the Medicare trust fund to allow, first, military retirees to take their Medicare money and take it to the doctor of their choice, including if the doctor of their choice happens to be a base hospital. I am curious to what extent the Veterans' Committee has looked at the same concept?

Because remember, every one of these veterans, if they have worked since the 1960's, they have been paying Medicare taxes, they have been paying into that trust fund. And I just think it makes abundant sense. And if you recall a couple years ago, the House voted by a huge margin to allow them to take their Medicare funds and use them at a base hospital. I was wondering to what extent the VA Committee, the Veterans' Committee has looked at the same concept?

And the second thing, and this is strictly off the top of my head, and if you addressed it earlier, I apologize. We also have a situation where, for lack of funds, we have empty buildings. We certainly have the need for health care. Veterans wait way too long in order to see a doctor.

Has anyone—starting with the concept of having that veteran take his Medicare with him to the veterans' hospital, has anyone given serious thought, since we already have the facility, since we already have the administrative folks, since we are already paying the overhead for the hospital, for the equipment and for all of the

things that any doctor needs that allowing doctors to practice at a VA hospital on a Medicare-reimbursed basis but we supply the buildings, the Administration, the insurance, if necessary, as a way of attracting additional doctors into the system, even if it is for just a day a week or a couple of days a week?

Because I am sure that the gentleman from Pensacola, he is right. Those folks from Pensacola drive to Biloxi, Mississippi to seek care. That is a long ways.

And quite frankly, it floods the system. It is inconvenient for the folks from Pensacola, but it floods the system in Biloxi, and so I have to believe that we have to find some clever ways to get more doctors in those buildings with the hand we are dealt, which is that we are still striving for a balanced budget. Have you all given much thought to that?

Mr. SMITH. Two very good questions. On the first, we are looking at, very actively, the whole issue of Medicare subvention. Our committee does not have the primary jurisdiction over that. The Ways and Means Committee would have the primary over that, but I think that is an idea perhaps whose time has certainly come, provided we do not use it as a line of demarcation to say we are not going to do the appropriation dollars anymore.

The fear is that will become an offset and our friends on the appropriations side will see that as a further disincentive to cough up the money necessary to make sure, especially Category 1 through 6, are adequately funded—the service connected, disabled, the POWs and the indigent veterans. So we want to make sure we lose absolutely no capacity there, and groups like the Paralyzed Veterans of America, the Disabled American Veterans and others speak very eloquently to those concerns, lest we ever lose sight of that, that subvention not become an offset.

But I do think since they have already paid, as you pointed out so well, Mr. Taylor, they have purchased their Medicare entitlement, why not take that entitlement and the money that goes with it and bring it to your VA health care facility? We do with third party insurance carriers and medical care cost recovery I think this year brought in $775 million or thereabouts. The expectation is that that will go up several hundred million more this year.

So we are already doing it in the private sector. Why not do it with the public sector monies? We probably will face a firestorm of animosity from the Centers for Medicare and Medicaid (CMS) and those people, but it seems to me that you go, medical dollars follow the person or the patient and ought to be—so I am very much in favor of subvention.

On the issue of having privileges in VA hospitals, I think that is one that we need to look at much more seriously. In terms of you talking about having additional doctors come in, our problem is not as much doctors as it is nurses. And just for the record, this past year, President Bush signed it, we passed a major health care bill that had, and Mr. Moran did yeoman's work on this to make sure that we have incentives to attract and retain, through scholarships, siphons and a slew of enhancements, nurses.

The average nurse in the VA health care system is about five years older than his or her counterpart in the private and public sector. So we are going to have a spate of potential retirements hit-

ting us and a loss of nursing care, which we need to get more nurses into the system. So I hope that answers your question.

Mr. TAYLOR. It sure did. And if anyone from CMS is listening, I would remind you you work for the citizens. And the citizens are saying that they would like to use the VA hospital, they would like to use the military hospitals. They have paid their dues, and they should be allowed to go to the hospital of their choice with their Medicare funds.

Thank both of the chairmen.

Mr. MCHUGH. Thank the gentleman. Also a member of the Armed Services full Committee who has joined us here today, the gentleman from Texas, Mr. Ortiz. Any questions for the witness?

Mr. ORTIZ. Thank you so much for having this hearing. Chris, good to see you. And I think that the objectives that—and I am sorry I am late, I was at another hearing. I think that I would like to tell my story. I have a Navy hospital in my district. It is a 195-bed hospital built in the 1960's, very good shape. We have at least 13,000 active duty personnel on the bases close to this hospital. We have a clinic. We need to share facilities, we need to work together. I have tried to introduce a bill for the past 14 years to try to build a hospital in south Texas. They tell me it is too expensive to build a hospital. Well, we have one that does not need to be built; it is there.

The people from south Texas, which is Brownsville, Harlingen, they have to travel 7 hours to get to the hospital in San Antonio, Texas. Some of these patients, ex-military people, are veterans. And the worst thing that—you know, they do not have a van to travel. They borrow a van to take them to the hospital in San Antonio. The worst place for them to meet—you know where they meet? They meet at a funeral home.

These people were young at one time. Like they say, some gave some, some gave all, and we are not treating them the way we should. Can you imagine you serve in the military, you are bedridden, the clinics cannot take care of you, you are supposed to go to the hospital, and it takes a seven-hour drive to go to the hospital?

Another gentleman from my district in Corpus Christi, which is closer, he gets on a bus. He goes to the hospital in San Antonio. He gets there at 9 o'clock in the morning, then they call to see him at 5 o'clock in the afternoon. The bus leaves back home. He has no money, he is 81 years old. I mean this is insane what we are doing.

I appreciate your help, Chris. And Chairman Hobson of the Appropriations Committee has been very helpful. We need to treat our veterans in a humane way. I mean it is sad the way we treat them. And I hope that we can look at the hospitals and looking at the bases that are there, but at hospitals where we can join forces to give them better services. And I would just like to applaud both chairmen for looking at this issue of seeing how we can better health services for our people who serve in our military.

We talk about retention problems, my friends. How are we going to be able to retain when we do not give them what we offered them in the beginning? And I thank you, Mr. Chairman, both of you, for giving me this opportunity to be here with you today.

Mr. MCHUGH. I thank the gentleman and for his efforts and his deep concern. Chairman Smith, that concludes the questions. On behalf of both subcommittees, I want to thank you again for your leadership, for your hard work and as you heard many members here say this morning, we hope this is not the end of this road but the beginning, and I know that is your desire as well. So thank you so much.

Mr. SMITH. Mr. Chairman, thank you very much for this opportunity. And I think, for the record, everyone should know that you are the undisputed best left fielder, and with our star pitcher gone, you are going to get a lot of action in the next baseball game.

Mr. MCHUGH. We will mark up your bill next week, Chris.

[Laughter.]

With that, be pleased to call forward the members of the second panel. We are pleased to be joined today by the Honorable Leo S. Mackay, who is Deputy Secretary of the Department of Veterans Affairs; the Honorable David S. Chu, Undersecretary of Defense for Personnel and Readiness; the Honorable Nancy Dorn, Deputy Director of the Office of Management and Budget; and Dr. Gail Wilensky, who is Co-chair of the President's Task Force To Improve Health Care Delivery For Our Nation's Veterans.

Welcome to you all. We are both pleased and honored that you have been able to join us. I am sure you heard the agreement that had been reached with respect to the five-minute rule and the summarization, to the greatest extent possible, of your written testimony. I have had now the chance to review them all in their entirety, and they will all be included in the record, which is very, as you know, an important part of that process.

So with that, we would read the names for recognition in the same order in which they were handed to me. So if there are any complaints, I would suggest you talk to staff.

But with that, Secretary Mackay, thank you very much, sir, for being here, and we look forward to your comments.

STATEMENTS OF LEO S. Mackay, DEPUTY SECRETARY, DEPARTMENT OF VETERANS AFFAIRS; DAVID S.C. CHU, UNDERSECRETARY OF DEFENSE FOR PERSONNEL AND READINESS; NANCY DORN, DEPUTY DIRECTOR, OFFICE OF MANAGEMENT AND BUDGET AND GAIL WILENSKY, CO-CHAIR, PRESIDENT'S TASK FORCE TO IMPROVE HEALTH CARE DELIVERY FOR OUR NATION'S VETERANS

Dr. MACKAY. Thank you, Mr. Chairman. It is an honor to be here. I am accompanied today not only by my fine colleagues here at the table but also by our acting Undersecretary for Health, Dr. Frances Murphy and also Al Pate, who is our Director at the North Chicago Veterans Administration Medical Center (VAMC), in Illinois.

I am pleased to be here today to discuss coordination of health care resources between my Department of VA and the Department of Defense. Administration has identified enhanced collaboration between the two Departments, and their health care system is one of its top priorities. It is mentioned in the President's management agenda as a priority item, one of 14 items so designated in that

agenda, and it is a matter of quite serious concern and focus between our two Departments.

There is no question that these actions have the potential to add great value to our services, increase management efficiency and expand the use of our facilities. Importantly, they hold the promise of a seamless transition from military to veterans status, something that I think we all would like to see.

I can assure you that VA, at the very top level and throughout VA, welcomes this opportunity to advance our partnership with the Department of Defense. I can also assure you that our mutual agenda of sharing is well underway. Central to this is the Joint Executive Council (Joint Council), which I chair with the gentleman to my left, Dr. Chu, the Undersecretary of Defense for Personnel and Readiness. The Council meets quarterly, and we had our first meeting in February.

And we are committed to establishing a framework necessary for the planning and execution of joint activities and initiatives. It is also committed to examining every opportunity for closer cooperation, to building strategies, developing a dual vision. That vision will allow us to move forward with the appropriate mix of skills, people, facilities, funds to best serve both beneficiary communities, yet maintain the integrity of our distinctive missions and communities that we serve.

Our concept will focus on what I believe is a key operative principle: measurable performance and quantifiable results. And by this I mean the establishment of matrics by which to mark program successes, resolve weaknesses and correct deficiencies.

The Joint Council's inaugural meeting, which I mentioned was last month, provided the opportunity for several issues that directly affect the future of our collaboration. Among these are joint procurement initiatives, information technology facilities and capital planning and enrollment. Particular attention was given to planning for the receipt of the recommendations of the President's Task Force To Improve Health Care Delivery For Our Nation's Veterans.

The Joint Council is acutely aware of its mission to infuse practical, common sense management into the closely aligned operation of the nation's two largest Departments. Dr. Chu and I take responsibility in this matter very seriously.

There are challenges ahead, to be sure, and though our systems undercount the value of the services we exchange between our two Departments, we are not satisfied that we do sufficient sharing or that we do it in an efficient manner. There have been some successes, however, although I will acknowledge very freely that much work needs to be done.

During the course of fiscal year 2001, we managed to avoid, through leverage purchase of pharmaceuticals, about $100 million in costs. And, recently, I was very privileged to sign with my good friend, Gordon England, Secretary of the Navy, a Memorandum of Understanding (MOU), in North Chicago that will provide the exchange of 48 acres of what is now VA property to a recruit training center in Great Lakes, while creating a partnership between VA and Navy to meet our joint energy needs.

We have some very tough obstacles with regard to sharing in TRICARE. And there are limits to sharing due to different struc-

tures, different purposes, authorities and missions between the two Departments. This is also a new team that you have before you to meet this challenge, but newness certainly is no excuse. The opportunity is clear, the rationale for extensive sharing between VA and DOD is compelling. We have ample authority that the Congress has given us. We have made some track record of success, but it is not enough. We are determined to deliver much more. Thank you, and I would be happy to answer any questions from members.

[The prepared statement of Dr. Mackay can be found in the Appendix on page 58.]

Mr. MCHUGH. Thank you, Mr. Secretary. We do have the edification, as members who may not have had a beeper, a 15-minute vote, final passage on the Job Creation and Worker Assistance Act, scheduled to be the last vote of the day.

Dr. Chu, perhaps we could listen to your testimony before, at least, I leave to go vote, if that would be possible.

Dr. CHU. Very good, sir. And I will be brief in those circumstances. Thank you, Mr. Chairman. It is a great privilege to be here and discuss with the committee our vision for how we can improve the partnership between the Department of Defense and the Veterans Administration in the delivery of health care. We put enormous value on that existing relationship. It is our hope that this becomes more than sharing over time and becomes indeed a proactive partnership, a strategic partnership between the two Departments.

I had the privilege in my first few months in office to travel around the country a little bit, and I have had the chance to visit half a dozen places where DOD and VA are already working together in various ways: Tripler Hospital where, as you know, the Army provides inpatient services to the Veterans Administration in the Hawaiian Islands; the Augusta, Georgia, area, where there is a partnership among the Medical College of Georgia, the VA Medical Center and the Eisenhower Medical Center, operated by the Army; the Denver-Colorado Springs area, where I think there is a very interesting opportunity to do further collaboration among the various institutions with our government in that important region; and just recently I had a chance to visit Nellis Air Force Base, which, as you know, is a joint Federal hospital.

And I am very impressed by not only the facts but the spirit of collaboration between the two agencies there. In fact, the Veterans Administration leadership has stepped forward. Since summer, the personnel at Nellis have been deployed to Central Asia and offered to provide some of the backfield that we will need to continue caring for those patients and for which we are very grateful.

And just last week, I had a chance to visit North Chicago, whose VA Hospital Director is with us this morning, where I do think there are some important opportunities for future collaboration on the part of the two Departments.

Indeed, I think it is important for us to recognize the degree to which leaders on the ground in the various institutions have already achieved significant success. There is more we can do, but I do hope we can acknowledge how much has been accomplished to date.

As Dr. Mackay indicated, we completed our first Joint Executive Council meeting very recently. The next one is scheduled for early May. We look to this group as our mechanism for building a more collaborative relationship, both on health care issues and also on benefit issues between the two cabinet Departments.

Perhaps one of the most important of those issues is how we establish a common reimbursement procedure, a standardized billing approach at the national level, that I think we both are convinced is a key element in encouraging a partnership across the entire United States, and that it will advance this vision of a true beneficial partnership between the two cabinet Departments.

Dr. Mackay has already mentioned one of the areas, I think, of success, which is pharmaceuticals procurement. By a fairly conservative estimate, we are already saving between the two agencies $100 million a year on this. And the Defense Department, as you know, has agreed to use the Veterans Administration Federal supply schedule not met by specific procurement contracts.

We are entering at the Department of Defense, as you are aware, Mr. Chairman, the construction of a new generation of TRICARE contracts. I am pleased that we have Veterans Administration personnel participating in our working groups, as we structure that next generation, and we look forward to their contributions.

And I am likewise pleased that we are making progress on the Federal Health Information Exchange, formerly known as the Government Computer-Based Patient Records, which will begin to deal with some of the information technology issues that the members this morning have mentioned in their questions.

One of the future agenda items to which I look forward is the establishment of a Joint Strategic Planning Committee, which will be one of the issues that we bring before this Joint Executive Council in the near future, which will enable us to do a better job of long-range strategic planning over the years of the first decade of the 21st century. We began this past year, in a modest way, by exchanging information on our construction programs and trying to be sure that those presented in the President's budget request for 2003 were as well-coordinated as we could make them.

Mr. Chairman, Dr. Mackay and I, I believe, share a common vision of quality health care for our men and women who serve our country, their families and those who have served in the past. DOD's concerns of the well-being of our service members extends beyond just their time on active duty. Collaborative efforts, we believe, with the VA will provide the best possible service through new initiatives and increased efficiency to the benefit of the service members, veterans and the nation's taxpayers.

Thank you, Mr. Chairman. I look forward to your questions.

[The prepared statement of Dr. Chu can be found in the Appendix on page 64.]

Mr. MCHUGH. Thank you very much, Mr. Secretary. To all of the panelists, both seated and waiting, I extend our apologies, but I will try to have members come back and resume as quickly as possible. As I said, there is one vote. So we will stand in recess until we return.

[Recess.]

Mr. MORAN. [Presiding.] Call the committee back to order. Due to the length of the first panel, consisting of one member, our hearing has gone longer than we had anticipated, which I hope reflects an interest in this topic. But because of that, Chairman McHugh has allowed me the opportunity to assume the gavel before the appointed hour. So I appreciate that opportunity and look forward to hearing the remaining testimony.

And I believe we are ready for Ms. Dorn from the Office of Management and Budget (OMB). Welcome back to the Hill.

Ms. DORN. Thank you, Mr. Chairman. I appreciate the opportunity to be here today with you and with my colleagues from VA and the Department of Defense.

We very much appreciate the opportunity to address an issue that is among the highest priorities of this Administration. My two bosses, Mitch Daniels, and the President, have invested a great deal in this issue and have laid out several markers, one of which was the first budget that the Bush Administration produced about a year ago. The second was in the President's management agenda, which featured a—one of the highlighted items was the coordination of DOD and VA health care systems, and then in the budget that we just submitted about a month ago.

I would hasten to say that this Administration wants to see results on a grand scale, not on an ad hoc basis. I think a good deal of work has been done over the years by good people reaching out and working with one another. But what we would like to see is a more policy-driven systemic sort of an approach whereby it is just not the efforts of a few individuals but it is the effort of the Administration as a whole.

I would emphasize from the start that this is not a budget-cutting drill. It is the management part of OMB that is really focused on the DOD-VA health care system integration. But our focus is on an effort to ensure better access and quality of care and seamless transition from active service to veteran status.

We applaud and have supported the task force, chaired by Dr. Wilensky, and we will continue to do so. We are particularly proud of the focus that the leadership of both the Department of Defense and the Department of Veterans Affairs have shown toward this issue. While sharing and coordination have taken place for years, this is the first time that the leadership of both Departments have ensured that this is a high priority and communicated and monitored the priority within their organizations on an ongoing basis. Together they are attacking global issues that can really start us toward the future in a constructive way.

I would just mention a couple of areas and then stop so we will have some time for questions. Two overarching areas of coordination that we are very interested in are information technology and facility sharing. These are key issues from the Office of Management and Budget's perspective. Sharing information technology can make a world of difference—speeding up service, ensuring safer health care and informing veterans of earned entitlement. In addition, it can transport information from one Department to another, continually providing fuel for innovation and improvement of service.

One other area of coordination of information technology that we are addressing is in the medical care area. Both DOD and VA create independent patient medical records, as has been mentioned earlier, and this is an area where we think we can make vast improvements.

I mentioned the President's management agenda. One of the specific items under this is the e-government initiative involving health care informatics, and development of a patient record system is one of these specifics. Developmental efforts in both Departments will focus on interoperable information technology solutions. This is a major effort, one which will likely require a sustained, multiyear effort to implement completely, but it is one that is certainly worth doing.

Active duty personnel, dependents and veterans all benefit by DOD and VA sharing facilities when appropriate. The two Departments share less than ten facilities today, but we look forward to making some improvements on that in the very near future. In many communities, DOD and VA hospitals are close together, as Chairman Smith noted. In many areas, we think we can achieve great advancements in delivery of services if we can get a coordinated, consolidated effort.

We are working with DOD and VA on a multitude of other coordination issues, including patient transportation and medical training, and we could talk about that in this hearing if there is time and interest.

Finally, let me address the President's proposal that would ensure that military retirees choose either DOD or VA as their health care provider through the annual enrollment season. This legislative proposal was included in both the fiscal year 2002 and 2003 President's budget and would ensure higher quality health care and more efficient use of resources. We believe it is imperative to coordinate the care provided to military retirees by these two agencies.

Under our proposal, retirees using both systems for health care in the same year would do so under managing physicians' oversight and direction. They would benefit from having one health care system arranged for all their health care and prescriptions. And this is something that we would very much like to work with the committees of jurisdiction on.

In closing, I hope that we can emphasize how important the DOD and VA coordination is to the President and some of the specific areas that the Administration is pursuing to ensure top quality services to military members and their families and veterans. We still have a lot of work to be done, as only about $100 million, less than a quarter of one percent, of a $40 billion budget of VA passes from one Department to another.

Mr. Chairman, members of the committee, we look forward to answering your questions and working with you on these important issues.

[The prepared statement of Ms. Dorn can be found in the Appendix on page 69.]

Mr. MORAN. Thank you so much for the OMB perspective. Dr. Wilensky, welcome and look forward to your testimony.

Dr. WILENSKY. Thank you. Mr. Chairman and members of the subcommittees, thank you for asking me to appear before you today to discuss health care sharing between the Department of Veterans Affairs and the Department of Defense. For those of you who I have not had a chance to meet before, my name is Gail Wilensky.

In addition to Co-chairing the President's Task Force To Improve Health Care Delivery For Our Nation's Veterans, I am also a Senior Fellow at Project HOPE, an international health education foundation. I have previously been the Administrator of the Health Care Financing Administration, referenced in earlier discussion. And I was the first chair of the Medicare Payment Advisory Commission.

The President created the task force last Memorial Day to honor a campaign pledge he had made to improve health care for veterans who have served this nation. And in that Executive Order, he outlined three major areas that he wanted the task force to look at. First, to identify ways to improve health care delivery of the services themselves; second, to identify barriers and challenges to making these improvements; and, finally, to find opportunities for better resource sharing between the VA and the DOD.

The task force has had its own challenges to overcome. Our first meeting was scheduled on September 12. Needless to say, it did not occur, and we started late. In addition, my co-chair, your former colleague, Congressman Jerry Solomon, unexpectedly died late in October, and that has disrupted the functioning of the task force and has certainly made it more difficult for me to provide leadership to this task force without him.

It has been a very positive experience because of the support that we have been able to get from the Department of Defense and from the Department of Veterans Affairs. And the gentlemen to my right are people who I have met with on several occasions. The executive branch, in general, OMB and the Domestic Policy Council have also been very helpful.

We are instructed to report to the President in July and we will do so and to have a final report at the end of the year. We have been working to understand in greater depth the problems that have prevented the VA and the DOD from engaging in more sharing, and we have done so by focusing on seven areas: benefit services, leadership and productivity, information management and technology, facilities, pharmaceuticals, acquisition and procurement and, finally, resources and budgeting.

We have had to recognize the fact that these two Departments treat different populations. They have different missions, they clearly have different cultures and traditions, and all of those impact the ability to have sharing occur. We are also reviewing the many recommendations that people have made in the past. As has been pointed out to us, and as all of you are aware, there have been several commissions preceding us. We want to understand which of the recommendations were implemented, and if they have not been implemented, what was the impediment toward their implementation?

We have staffed these work groups with some consultants who are not only subject matter consultants but who come out of the VA and DOD. We thought it was very important that we have people

on board who understand those cultures. We have also, with only a little prodding, been able to have some excellent detailees from both the VA and the DOD assigned to the task force, and they, with subject matter expertise, along with a small, more permanent staff, formed the basis of the people who are doing the staff work for the task force.

We have been meeting regularly once a month. Some months we are meeting on more than 1 day. We have been meeting informally with various service organizations. We have met with two out of three Surgeons Generals thus far. We will meet with the third shortly. We have had numerous meetings with people on the Hill. We have been meeting with people from the VA and DOD Departments themselves.

And we have started to make a number of trips so that we also can understand what seems to have been responsible for some of the sharing activities that have been successful. And last month we visited Las Vegas, Nellis Air Force Base (AFB) and their sharing arrangement with the VA, and Kirkland (AFB) in Albuquerque as well. We will make a number of other trips later this spring, and last fall there was a trip made to Alaska to understand how things were working there. It allows us to have a better feel for what seems to have made the difference in those areas where these sharing ventures have occurred.

Obviously, when there is a co-location and there are times where one needs to expand where the other is already there, there is an easy win-win. But we want to emphasize that we are looking at more than just the mechanics of physical sharing and joint venture. We think they are important, but we think they are only one end of a continuum of better cooperation and sharing. If we rely solely on physical joint ventures, we think there will be very limited sharing relative to the potential that is out there.

Success in these activities requires leadership, that is clear. Good leadership can overcome our other problems, but we want to institute the kinds of procedures that if carried out will allow these activities to continue beyond the individuals who are present.

Finally, the mission of the task force is not to lay blame, nor is it to try to remake the health care systems of the VA and the DOD. But we do hope that when the recommendations are carried out, that we bring forward to the President they will improve the delivery of health care to our nation's veterans. We believe, to coin a term, use a term that is used many times before, that the system will work much better for the retirees and the veterans if the process becomes seamless and transparent. I thought I had known difficulties in trying to improve the Medicare system, but I must admit that this has been even a more challenging situation. Thank you.

[The prepared statement of Dr. Wilensky can be found in the Appendix on page 71.]

Mr. MORAN. Doctor, thank you very much. Let me begin with just a couple questions for you, Dr. Wilensky. What point in time should we have a recommendation?

Dr. WILENSKY. Our plan is in July we will have our interim report. It is our expectation there will be some broad level recommendations, more of the 10,000-to 30,000-foot level rec-

ommendations across the area, a vision chapter that describes where we see this system going, and in some areas, some specific recommendations, probably pharmaceutical facilities, those areas that are easier to get our arms around.

The final report, which will not be until a year from now, in March of 2003, will contain more detailed recommendations in areas that we anticipate will be a little more complicated, like information technology systems, where trying to understand the difference between having a single system and having systems that can communicate with each other through some kind of a crosswalk will require some sustained effort. So some recommendations, July, before you go out, before the Congress goes out, and the rest in March.

Mr. MORAN. Thank you. Are there incentives currently in place that encourage DOD and VA to cooperate and pursue this strategy?

Dr. WILENSKY. There certainly are not very many incentives. The way the promotion systems work in the military do not lend incentives or rewards for sharing, per se. There is not an explicit reward structure that I am aware of in the VA, either that explicitly rewards this type of activity.

What we believe will be an important incentive has been mentioned earlier this morning, and that is the fact that there is a base closing process going on. It will mean some disconnectedness between where some of the retirees live and where they have been used to receiving their health care. And on the VA side, they are shifting populations. The changing demographics of the veterans themselves may also lend itself to an interest in greater cooperation.

So we are hopeful that some of the natural changes occurring in both the VA and the DOD, if combined with some better direct incentives would help this process.

Mr. MORAN. If there are no or, at minimum, few incentives, there are barriers, is that true?

Dr. WILENSKY. There are clearly barriers.

Mr. MORAN. And are those barriers—I assume the answer to this question is that they are administrative, they are budgetary, they are cultural. Would you outline——

Dr. WILENSKY. I will give you some examples. Sometimes they are legislative as well. And that is they certainly are cultural differences. They are institutional attachments. Probably comes as no surprise that people who identify themselves with the Veterans Administration have very strong feelings of wanting to have their care in a VA facility and when we were out at Nellis, there was clearly some tension as to who was getting served first and whether it would have been the same if it had been purely theirs. And the same is true on the military side—very strong feelings toward the military facility—this is where they have been receiving care—and some reluctance to change those identifications.

Sometimes there are legislative differences because of the benefit structure differences that may be available to each. Sometimes it will be because of the population differences in terms of the age differences and whether or not they are treating family members or just the veteran directly in the case.

So there are a lot of obstacles. But if you think about it as better coordination rather than only the physical jointness of a joint venture, the potential to have processes that allow communication back and forth, that have pharmaceutical purchasing or a procurement that make use of the power of these two Departments becomes much greater because you are far less limited by some of the differences that will sometimes make physical sharing more difficult.

Mr. MORAN. Doctor, thank you. Before my time expires, Ms. Dorn, Chairman Smith testified about his bill. He introduced it last year. I think he has requested the Administration's view on that legislation. Is that something that the Administration is looking at, and could we anticipate a response?

Ms. DORN. Yes, sir. We are hard at work at gathering the agency's views on this and looking at the specifics of the legislation. I think there is consensus that there are some good ideas in there, but we hope to be able to communicate those officially to Congress in the fairly near future.

Mr. MORAN. Thank you very much. My time has expired but let me thank Dr. Mackay for being here, welcome him to his initial debut before our subcommittee and congratulate you and wish you well on your new position at the Department of Veterans Affairs.

Dr. MACKAY. Thank you, Mr. Chairman, that is quite gracious.

Mr. MORAN. I look forward to working with you, thank you. Dr. Snyder.

Dr. SNYDER. Thank you, Mr. Chairman. Dr. Mackay and Dr. Chu, I have one question I would just like you to respond for the record, please, and that question is what do you anticipate will be your turnaround time in responding to questions for the record? This will be like a contest.

In the answers we got back a couple days ago that were asked eight or 9 months ago, the question was do performance evaluations within the VA include efforts on resource sharing? And Dr. Garthwaite's answer was that the performance plan contains no specific requirement regarding VA–DOD sharing.

However, the performance plan does specify a number of core competencies that are designed so as to allow for an assessment of each director's executive performance. The core competency, flexibility, adaptability include the assessment of a director's ability in allocating resources in an effective manner and utilizing a full range of approaches which include contract and sharing agreements to reach desired outcomes.

Where do you think we are today, Dr. Mackay and Dr. Chu, with regard to evaluation of employees in your systems, with regard to resource sharing with your counterpart?

Dr. CHU. I think this is one of the issues, Mr. Chairman, that in our joint effort we are going to have to pay more attention to, because I think the import of your question is obviously on the mark that what you measure is what people perform against. I would have to be candid and acknowledge that I do not think this has been something that the personnel system has put high on the agenda before, but it is the kind of thing that we need to going forward.

Dr. MACKAY. Yes. I have to agree with Dr. Chu and also with Dr. Garthwaite, that there is no specific measure right now that goes to health care resources. I think also we need to say that we do not do as good a job as we could—and this is one of the things that Dr. Chu hopes to remedy—in giving our facility directors the tools. One of the chief impediments that we have found to sharing between VA and DOD is the lack of a joint or a settled upon price list, if you will, between benefits and services.

And there are a couple of consequences for that. They have to generate these price lists or schedules of billing and reimbursement themselves, and they do that in places like Travis AFB and other places where we have a good deal of sharing. And so we need to make—a standard list of billing and reimbursement would make that much, much easier to do. It would always be there to use, and it would certainly be a measure of flexibility and executive creativity if they used an existing schedule.

I think that is a critical obstacle that we need to get out of the path of both managers in VA and DOD, and it is the top priority in our Joint Council.

Dr. SNYDER. Dr. Wilensky, I wanted to pursue a little bit some of the comments you made but also that Chairman Moran made about the culture. You referred to the environment as a more challenging situation than you had with the Health Care Financing Administration (HCFA), which my guess is Mr. Scully (Administrator of CMS) would find that to be a flabbergasting comment.

But you talk about the need for better coordination. I used the metaphor of how do you get a fish to feel the wet, to acknowledge that there actually is something different out there than what we are doing. Do you have any—probably coming from your HCFA experience—any suggestions to these subcommittees with regard to—aside from we have a legislative proposal, we are now fairly dramatically sending a message in terms of oversight role. I mean do you have any specific suggestions, based on your experience, of some tools that might be appropriate to see that the right thing is done?

Because the reality may be we are calling this a cultural thing. I mean there good opinions that say this will not work, and what we want to have is a system that says, "Well, yes, this sharing will work, this sharing will not work," and then we all have confidence that those conclusions are correct. Do you have any suggestions on how to monitor and move the ball along the field?

Dr. WILENSKY. I would be glad to give some more thoughts on this and give you a written response.

Dr. SNYDER. Oh, that means a question for the record, you know, Dr. Wilensky.

Dr. WILENSKY. Let me give you some immediate reactions. One is a constant monitoring. There is nothing like having high-level reporting back to the Congress what has and has not been done to force attention to the issue. So I would encourage you to consider this in a serious oversight way.

I am impressed with the discussions that I have had with Dr. Chu and Dr. Mackay and Secretary Principi also, that they regard this seriously, that they would like this to happen and are frustrated that there has been so little progress. I am impressed that

both these gentlemen are involved in resurrecting the council that had not been active to try to work out sharing. So it is my impression that they are looking to find ways to have this happen.

Basically, it has to be clearly in both of their interests, both Departments have to feel that they are getting something out of working together that they are not likely to get if they do not or it is not going to happen.

And part of it, I think, is having the Congress truly believe, and the GAO as well, that efforts to coordinate are as important as efforts of physically joint sharing. I think there has been a little bit too much emphasis on having to have the joint facilities. Sometimes that makes sense. It is my conclusion if that is the only thing that gets to count this is not going to be a very big activity.

Places are where they are. If you have to build someplace, you definitely ought to put enormous emphasis on looking to see what is there and not countenance foot dragging to make use of the other side's facility. A discussion I had with Dr. Chu suggested sometimes not being in the same place is an advantage because the people using the services may be scattered as well, again, sensibly finding ways to do that.

The biggest effort to date, the actual successful sharing each time seemed to have happened because the individuals. Frequently, or at least in a couple of cases, the military commander had retired, gone over to the VA system. You have literally a linkage at the top level between these two and that the leadership, the personalities drove this to happen. That is terrific, but obviously, you cannot count on that as a way to have major change.

So what you need to try to find are institutional ways to have these activities occur. Part of it is going to be the incentive of promotion. Certainly, as an economist, I believe people will perform to what they are being measured against, and if the incentives are there, you will drive change.

Dr. SNYDER. Thank you. It may be helpful, if you have some further thoughts, to pass them on to the committee.

Dr. WILENSKY. I would be glad to.

Dr. SNYDER. Thank you, Dr. Wilensky. Thank you, Mr. Chairman.

Mr. MORAN. Mr. Wilson.

Mr. WILSON. Thank you, Mr. Chairman. I would like to thank the panel for what you to do to improve health care delivery to the veterans. It means so much to me, as I have a huge veterans community that I represent, and they greatly appreciate it.

And I want to give a report to Dr. Mackay that I had a district meeting 3 weeks ago, and it was at the Dorn VA Hospital. And I was very impressed that it was widely advertised that we would have this meeting on veterans' issues. And it amazed me that people came and actually had—instead of horror stories, people came and were asking questions. But in the process of asking question, indicating the quality of care that they received, that they felt like it was first class. So I just want to thank all of you and the entire panel for being here today. Thank you, Mr. Chairman.

Mr. MORAN. Mr. Ortiz.

Mr. ORTIZ. Thank you, Mr. Chairman. I also would like to thank the panel for being with us today. I just have maybe a couple of

questions that are not really parochial questions. Because all we have to do is look at the redistricting and some of the states lose members and some of the states gain. It just so happens that we have a big population of elderly veterans who are now moving south because of the weather conditions.

With the authorization and appropriations of funds for a joint DOD and VA demonstration program for joint service facilities, where are you in the process, and is Corpus Christi Naval Hospital being considered as one of the sites for studies?

Dr. MACKAY. Well, Congressman, I am certainly aware of the situation in Corpus Christi; in fact, the network director, Mr. Stranova, will be coming to Washington in the next few days and will be meeting with myself, with Acting Undersecretary Murphy, as well as the Navy Surgeon General. There is a work group, as I am sure you are well aware, that is underway. We are going to take a good, hard look at the kind of things that you brought out.

I grew up in San Antonio. I was born over at Wilford Hall Medical Center. I went to flight school in the Navy down in Beeville. So when you say the distances and the good people of south Texas, I am one of them, and I know what you speak of. So this certainly has our attention, and we will be taking a very close look at it and reporting back to you and staying in close contact with you and your office, sir.

Mr. ORTIZ. Thank you, because, as you just stated, you are familiar with the distance. Corpus Christi is about two and a half, three hours away. But there is a larger population as you go south. And this is the biggest growing area in the United States, the valley in south Texas, Harlingen, McAllen, Edinburg, Corpus Christi, I could go on and on.

But if I understand correctly now, the fiscal year 2002 VA-HUD appropriations bill directs the VA to give us the plans by September 1 of this year for the three demonstrationsites. And the growing number of south Texas veterans illustrates the need.

I mean we have a hospital that is not being utilized. We have the veterans population, we have 13,000 active duty. I just hope that by then that maybe you can finish your study and that we can get a copy of it so that we can continue to work with you and DOD so that we can come up with a plan and see how we can fix this problem that has been there for many, many years. We are talking about population-wise maybe 3, 4 million people in that area.

Dr. MACKAY. Congressman, we are certainly committed to working with you. I think we will really take a look at the migratory patterns of veterans moving from certain parts of the country and the impact of demographics within our CARES study, the Capital Asset Realignment for Enhanced Services. And we will be looking to match growths in veteran population, growth in demand for services with our infrastructure.

We have some very profound demographics going on in the veteran population. They mirror those in the broader community, but there are certain perturbations because of characteristics within the veteran population. And in that study, we will be making some major announcements about phase two this month, as a matter of fact.

We will also be working very closely with Department of Defense officials to look at the integrated long-term needs of the veteran population over the next 20 years. And we will certainly be looking at places like Arizona and Florida, Texas, of course, that are in the sunbelt that are receiving large inflows of more elderly veterans and moving to accommodate those.

Mr. ORTIZ. Thank you so much. You know, when the Secretary testified, I was able to take the opportunity with working from the top down. As you well know, I talked to Secretary Rumsfeld, Secretary Principi, and now I am so glad that all of you are here today. Thank you so much. Mr. Chairman, thank you for your time.

Mr. MORAN. Thank you, Mr. Ortiz. Mr. Kirk?

Mr. KIRK. Thank you and thank you for the courtesy since I have deserted this subcommittee to still be here. And I thank you. I also want to thank Dr. Mackay for coming, and it is great that you have given up your F–14 to help lead the VA. And Dr. Chu, we were very glad to have you at Great Lakes to see what is happening there. And, Nancy, for many, many years, and congratulations on your new position. And, Dr. Wilensky, probably no one knows about paying for health care better than you do.

I also want to thank—we have the legendary director of the North Chicago VA Medical Center behind you, Al Pate, and I would hope that as we enter this vision of combining the VA with the Navy, that he gets a separate chain of command so he can put his pedal to the metal and move that.

First question for Dr. Chu. We have a tangible combination of Army and VA, we have a tangible combination of Air Force and VA—Nellis facility. I am obviously hoping that North Chicago will be the tangible combination of Navy with VA. Can you talk about your vision of where you want to go with that?

Dr. CHU. Well, we hope to achieve, as a result—as you indicated, I had a chance to visit there just last week. I am convinced that there is the opportunity for working together. There are some specific challenges in terms of the actual land arrangements and the actual conditions of various facilities. But there is no doubt that we could do better by, in a partnering way, combining our efforts in that particular location. And I am comfortable we will come to a good solution.

We have a working group that has been charged with gathering the facts and figures that are necessary to make a good business decision here. It has to come back to us in the late spring timeframe. And so I am very hopeful that shortly thereafter we can evaluate the options and decide on a course of action.

Mr. KIRK. Mr. Chairman, Dr. Mackay and Secretary of Navy England really moved this forward in a very tangible way by swapping land, and we have now got a joint power generation. If you could talk about that, because we have some tangible real combinations going on right now in North Chicago in where we are going.

Dr. MACKAY. Thank you, Congressman. I would be happy to talk about that. The memorandum of understanding covers the first part of what we hope is going to be a two-stage system of cooperation, and really indicative of the kind of systemic structural change and cooperation that DOD and VA can do going forward.

The first part of this was an energy-for-land deal. We took advantage of enhanced use lease authority that the Congress has very generously provided to the Department of Veterans Affairs. They have a five megawatt co-generation plant producing both energy and steam. And covering the energy needs of our North Chicago VAMC but also the energy needs of an expansion of the recruit training center in Great Lakes. The Navy, when I was part of the Navy, had three recruit training centers. They have one, and they need to have major expansion at the site.

We are going to transfer free a permit to the Navy to expand on our grounds. It will be a very good thing for the Navy. It will allow them to actually do this expansion while not moving people to temporary and transient facilities, which I understand is obviously a big plus so they can keep up their training flow as they make these major improvements to their infrastructure. It is an energy-for-land deal, it is a good partnership, and it really binds us together in ways that force us to partner.

It is not a merger. I think Dr. Wilensky was very wise in the things that she said about not focusing on the bricks and mortar entirely. Structures of cooperation, patterns of partnership, deep cooperation, collaboration and coordination, all those good C words are important. And this is indicative of the kind of cooperation we can have when we have good local officials like Dr. Pate and the Navy commanders, as well as high-level involvement. And I am also very grateful to you for your leadership. You have been a staunch supporter, and many times it was critical to have your involvement.

Mr. KIRK. I want to get into that theological discussion too, because it is not just bricks and mortar, and this is—when we looked at this before, you look at HCFA, now CMS, weighing in at 400 plus prescription drugs, a $700 billion health delivery system, compared to the little VA of $25 billion or at even smaller, military, in the $10 billion to $15 billion. And the initial reaction of this body is to say, "Have CMS do it, because that is how the Federal Government pays for 90 percent of the health care we already use."

The Navy Surgeon General visited me and talked about something far less complicated which is automated data systems which will mine the data sets from the VA and the military and be able—in other words, to translate between one financial system and another.

I wonder if, Dr. Chu, you could talk about that, and then Dr. Wilensky. Which approach do you think we should use?

Dr. CHU. I fully subscribe to what Dr. Wilensky outlined, that this is much more than about bricks and mortar and that while there are some bricks and mortar opportunities, and we should take those, that the larger opportunity is how we partner to serve what is an overlapping population. And I think there are many places in the United States where we could do that. Congressman Ortiz pointed out one set of opportunities in his region. I have had the chance to see what I think is potentially a similar set of opportunities in the Denver-Colorado Springs area of the United States.

I am delighted that some of our TRICARE contractors take a similar view and are aggressively trying to promote the use of VA facilities as part of their networks. And I think all these are ingre-

dients in a long-term better solution, both for those for whom we owe the care as well as for the taxpayer.

Dr. WILENSKY. CMS is having its hands full at the moment. I continue to testify quite frequently on Medicare and Medicaid and other changes in health care. And to really understand the differences most clearly is to realize that both the VA and DOD are direct delivery systems, for the most part. TRICARE is an exception. Whereas what the Federal Government does with Medicare and Medicaid is typically finance health care that is privately provided.

So while you could think about having this health care be taken up by CMS, it would mean to walk away from the tradition of direct delivery, and that is a decision that would need to be made on other grounds as to whether this was regarded as desirable.

The kinds of transference of information, the ability to integrate supplies and to bill in the same ways is very important to sharing. Dr. Chu and I have had several discussions about the importance of having VA and DOD use a single billing system so that when they do swap services there is no question about how to bill, how to compensate for this.

I think one of the biggest questions that we are going to have to answer as a task force is how important is physically using the same information systems, as opposed to having a crosswalk between different information systems? For better or worse, the VA and the military have grown up with different systems, and I suspect it may be very difficult to literally force uniformity in those systems.

If we can find a way to crosswalk, we may be able to accomplish most of what we would like with a tenth of the effort, both cultural and financial, to go to a single system. Those are the kinds of issues that we are going to grapple with over the next few months before making recommendations in the task force.

Mr. KIRK. Thank you. Mr. Chairman, this field has been somewhat active, but I can say in northern Illinois it is the hot issue. And I really commend you for leading, because you are leading. And thank you for your testimony.

Dr. WILENSKY. We are planning also to make a visit to your area.

Mr. KIRK. Great. Thank you.

Mr. MORAN. Mr. Kirk, thank you. Thank you for being with us today, and we appreciate our panel's testimony, look forward to working with you as this issue continues to evolve. Thank you.

We would welcome our third panel to the table. Robert Washington is the Director of Membership Services for the Fleet Reserve Association and the Co-chair of the Military Coalition Health Care Committee; Deirdre Parke Holleman is the Co-chair of the Health Care Committee of the National Military Veterans Allliance; Steve Robertson, the Director of Legislative Affairs for The American Legion; Harley Thomas, Health Policy Analyst for The Paralyzed Veterans of America; Joy Ilem, Assistant National Legislative Director for Disabled American Veterans; and Dennis Cullinan, Director of Legislative Services for the Veterans of Foreign Wars of the United States. We welcome you all to this joint meeting of our subcommittees. Mr. Washington.

STATEMENTS OF ROBERT WASHINGTON, DIRECTOR, MEMBERSHIP SERVICES, FLEET RESERVE ASSOCIATION, CO-CHAIR, THE MILITARY COALITION, HEALTH CARE COMMITTEE; DEIRDRE PARKE HOLLEMAN, CO-CHAIR, HEALTH CARE COMMITTEE, NATIONAL MILITARY VETERANS ALLIANCE; STEVE ROBERTSON, DIRECTOR, LEGISLATIVE AFFAIRS, THE AMERICAN LEGION; HARLEY THOMAS, HEALTH POLICY ANALYST, PARALYZED VETERANS OF AMERICA; JOY J. ILEM, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS, AND DENNIS CULLINAN, DIRECTOR OF LEGISLATIVE SERVICES, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. WASHINGTON. Thank you. Mr. Chairman and distinguished members of the subcommittee, The Military Coalition (The Coalition) is grateful for this opportunity express our views concerning issues affecting the uniformed services community.

The Coalition position on VA–DOD health care sharing is clear: The coalition supports any efforts to improve coordination between the two Departments, but only if those efforts would enhance or maintain access to quality care for beneficiaries of each Department. The final outcome should reflect either a continuation of benefits at the same level or enhanced benefits for all beneficiaries. Budget-driven decisions should not be implemented if it will negatively impact beneficiaries. We look to greater collaboration, not substitution or integration as the solution.

Near-term opportunities, The Coalition recommends that DOD and VA jointly evaluate the current barriers to TRICARE, optimizing the use of the VA as a TRICARE network provider and recommend increased coordination between the VA and the TRICARE Management Activity.

The Coalition recommends greater collaboration between the DOD and VA medical systems in military medical surveillance and force health protection since the outcome of such work is beneficial both to national security and the veterans' health care and disability claims.

The Coalition strongly recommends development and deployment of a common DOD-VA medical record as quickly as possible, along with the capability to exchange data seamlessly between the two systems using appropriate privacy protections. The Coalition recommends a review of the pharmaceutical practices of both Departments and mail order pharmacies and urges improved cooperation between the two agencies in this area.

Mid-term opportunities, The Coalition recommends DOD-VA develop and deploy a comprehensive, lifelong medical record for each service member. The Coalition recommends development of a strategic plan for joint procurement of high cost equipment and supplies, consistent with each agency's mission requirements.

The Coalition continues to support testing the feasibility of using Medicare funds in VA facilities for the non-service connected care of Medicare-eligible veterans.

Long-term opportunities, The Coalition strongly recommends upholding the principle that military retired veterans have earned and deserve access to both VA and VA CARES system, and they must not be forced to forego either benefit. Budget-driven proposals

should be resolved by the DOD and VA and not placed on the backs of those who have earned those benefits through service to their country.

The DOD and VA Executive Council have reported on ways they are collaborating in contracting, purchasing, administrative and maintenance services. This variety of arrangement, if properly administered and evaluated, could provide models for future collaboration. The two systems can and should work closely together to develop quality health care, graduate medical education, and specialty care centers of excellence. The Coalition encourages collaborative ventures as part of an overall strategy initiative with a primary focus on the needs of each system's beneficiaries.

Thank for the opportunity to present The Coalition's views on these important topics, and I am pleased to answer any questions that you may have.

[The prepared statement of Mr. Washington can be found in the Appendix on page 72.]

Mr. MORAN. Thank you very much, Mr. Washington.Mrs. Holleman.

Ms. HOLLEMAN. Good afternoon, Mr. Chairmen, members of the committees. The Military and Veterans Alliance is very grateful for the invitation to discuss this question that is of supreme importance to a great many of our members. Like the other speakers, the Alliance is fully in favor of cooperation and coordination between the health care programs of DOD and VA, if it can be accomplished without forced choice and while maintaining or improving the health care benefits presently available to the differing groups of affected beneficiaries.

Before coordination can widely occur, it is clear that the two different Departments' computers and more importantly, their staffs must be able to speak to each other. This is true if transferring medical charts, checking on drug reactions or writing bills.

When we look at the health care billing problems faced by the Department of Defense, the VA and Medicare, it is clear that we are dealing with a tower of bibles. If one system was used, coordination among the Departments could occur far more smoothly. Since almost all the nation's hospitals, doctors and insurance companies are used to talking Medicare, it is the Alliance's suggestion that DOD and VA follow Medicare's claim forms, language and definitions.

Clearly, Medicare must be included in this coordination effort if meaningful cooperation is going to result. If this was done, subvention of both DOD and the VA could be possible. Money could hopefully be collected. Through efficiencies made possible by this coordination, money could be saved. This could also simplify the lives of both the patient and the health care professionals—a worthy goal in and of itself.

When looking at the pharmacy part of the two health care programs, it is probable that financial savings could be achieved if joint purchasing at single mail order programs and a coordinated method of distribution with each Department serving the other's beneficiaries could be established. Purchasing drugs in such massive bulk should save money.

If the VA would accept private doctors' prescriptions, as TRICARE does, DOD could save a great deal of money providing drugs for their geographically scattered beneficiaries. This single change could also ameliorate the recent huge increase in requested VA appointments that are now required, and were always required, so a VA beneficiary can have a prescription written or refilled.

A long-term dream of DOD-VA cooperation is the creation of a health care network consisting of a region's military treatment facility (MTF), its VISN and the civilian TRICARE network. Presently, there is a test program in the central TRICARE region creating a network of all three groups. If successful, it could be used as the model for other regions' sharing and coordination plans.

The goal of cooperation and coordination is something that we can all agree upon, but the devil is in the details. We should start coordination cautiously and focus upon finite projects. While we can build on success, an early failure could stop the whole movement cold.

Looking at combining drug purchasing and distribution and coordinating information technology will be large steps and improvements in themselves. If successful, they can be huge stepping stones for further coordination. From there, based upon the conclusions of the Presidential task force, further cooperation can occur. And with that, better health care systems for each Department, and most importantly, better health care for all the beneficiaries would result.

Thank you very much for your attention. I would be happy to try to answer any questions you may have.

[The prepared statement of Ms. Holleman can be found in the Appendix on page 84.]

Mr. MORAN. Thank you very much. Mr. Robertson.

Mr. ROBERTSON. Thank you, Mr. Chairman. The American Legion appreciates the opportunity to be here, but in the same token, we are very disappointed that we are here. The fact that the military and DOD and VA has had this opportunity for a couple of decades now, we are disappointed that we are having to come here and address this issue, especially as veterans who are taught from the very beginning of basic training how important teamwork is.

We are taught to depend on each other to identify our friendly forces and let those that have expertise excel in those areas. And most importantly, taking care of each other. This does not end when your military service is terminated.

Obviously, recommendations and legislation are meaningless unless you have buy-in. There are plenty of people with very creative minds. It is much easier to sit there and give lists of reasons why you cannot do something rather than working full out to make these things occur.

Right now there are a lot of internal and external factors that are driving more and more veterans to the VA. We have seen the health care industry in the private sector collapse in many areas. And more and more veterans are having to come to the VA. If you look back before the Eligibility Reform Act of 1996, there were about 2.5 million veterans in the VA system. One group of veterans, who are now the Priority Group 7, were pretty much left completely out of the system.

We have seen this tremendous growth to where we are almost at 6 million enrolled veterans in the VA system, and they are anticipating it will go up to 8 million by 2010. We have to address these issues now. The American Legion's not opposed to veterans paying for health care in the system. Clearly, Title 38 identifies those veterans who are entitled to care. Active duty personnel and their dependents are entitled to care; military retirees are entitled to care.

We have to figure out alternative ways to make these things work. We talked about Medicare subvention today. I think Congressman Taylor was right on target, this is a prepaid benefit that we should all be allowed to pick and choose where we want to use those health care dollars. Legislation is what makes those rules happen. The restrictions are allowing it to take place.

Another issue that has been brought up is proposals by the Administration that are going to create this $1,500 deductible for veterans going to the VA. Unfortunately, that is going to attack a lot of veterans least likely to be able to afford insurance. If they had third party health care coverage, there would not be a problem for them going to the VA. But this may be a strain on them. So we are turning away veterans in their time of need, in their time of need for health care. That is not the way the military trained us to be soldiers. That is not what I think a grateful nation had intended.

Right now, this committee's discussion will have a tremendous impact on recruitment and retention. Look at the young men and women in Afghanistan today and the heroic actions that they are taking. You do that when you care about your fellow veterans. When they take off the uniform, they are not expendable; they are still a national treasure. Thank you very much.

[The prepared statement of Mr. Robertson can be found in the Appendix on page 89.]

Mr. MORAN. Thank you very much.Ms. Ilem.

Ms. ILEM. Thank you, Mr. Chairman. On behalf of the more than one million members of Disabled American Veterans (DAV) and its auxiliary, I am pleased to express our views on health care sharing by the Department of Defense and Department of Veterans Affairs.

We recognize the need and appreciate the subcommittee's interest in improving coordination and sharing between VA and DOD to improve access for beneficiaries of both systems. DAV continues to support sensible expansion of VA–DOD sharing agreements, and we agree that both Departments must commit to exploring new avenues for significantly improving health resources sharing and to building organizational cultures supportive of health resources sharing. However, DAV is adamantly opposed to a merger of the two systems or any other proposal that would erode the integrity of the VA system as a separate entity.

Our nation's disabled veterans deserve a system solely dedicated to addressing their health care needs. VA is able to meet many of their unique needs through a specialized health care service such as blind rehabilitation, spinal cord injury care, post-traumatic stress disorder treatment and prosthetic services.

We are concerned about legislative proposals in Congress that would contract our veterans health care to the private sector or cre-

ate some sort of a hybrid VA–DOD health care system. DAV is concerned that these initiatives are primarily cost reduction efforts with potentially negative effects on services for both VA and DOD beneficiary populations.

We do recognize and support sharing initiatives and purchasing pharmaceuticals, medical equipment, supplies and certain support services as well as the need for improved information exchange between the two systems. Where local situations favor sharing, it should be encouraged, but a mandatory national approach is likely to work to the detriment of beneficiaries.

Additionally, we do not believe there are any savings to be gained by forcing patients to choose one system over the other, as proposed by the Administration. The subcommittees have asked us to make recommendations with respect to improving sharing between VA and DOD and our views on what can be done now in the short term to increase coordination and joint ventures between the respective agencies.

Initially, we suggest the VA–DOD Secretaries set up strategic goals to initiate improved cooperation between the Departments. A best practices model could also be developed to give facilities with sharing potential the advantage of positive outcomes relating to joint ventures. In regional areas where VA and DOD facilities are co-located, local managers should be encouraged to develop joint working groups to explore the possibility of sharing opportunities, and facility directors should be rewarded for successfully negotiating sharing agreements.

Clearly, we want Federal health care resources to be used effectively in order to enhance access to high quality health care services for all eligible beneficiaries. We look forward to the recommendations of the VA–DOD Executive and Health Benefits Council and the President's Task Force To Improve Health Care Delivery For Our Nation's Veterans.

In closing, we would also ask the subcommittees to consider the issues of Medicare subvention and entitlement to VA health care for core priority groups one through six, which we have fully discussed in our written testimony. We believe these issues are relevant to the issue of sharing because they would ensure that annual spending levels for VA would be sufficient to provide health care for all eligible veterans. It would also provide needed stability in VA's planning for the future.

Mr. Chairman, that concludes my statement, and I will be happy to answer any questions.

[The prepared statement of Ms. Ilem can be found in the Appendix on page 95.]

Mr. MORAN. Thank you. Mr Cullinan.

Mr. CULLINAN. Thank you very much, Mr. Chairman, members of the committee. On behalf of the men and women of the Veterans of Foreign Wars (VFW), of the United States and our Ladies' Auxiliary, I want to thank you for inviting us to participate in today's most important forum.

Before we address the opportunities for sharing between DOD and VA, we too believe that it is important to emphasize that they are two separate and distinct entities with different missions: One, to fight and win the nation's wars, and the other to care for those

who bear the scars from those wars. While we strongly support and encourage their working together to best provide health care to their patient population, they and their missions must remain separate and distinct.

It is also evident that they both possess cultural and institutional barriers that must be broken down, or at the very least mitigated, in order to better create a health care partnership. We know from experience that this is easier said than done. And something else that has been said on numerous occasions here today, paramount toward this end of allowing them to work better together, to break down the institutional barriers is seamless recordkeeping, the smooth transmission of data between their respective systems, be it health care data, financial or what have you.

We were not surprised to find that a sound working relationship has been slow to develop. This unhurried pace is evidenced by the fact that while both systems have been authorized to share health care resources for nearly 20 years, they share only $62 million of a combined $32 billion— plus health care budget. Recent testimony by Congressional oversight staff before the President's Task Force To Improve Health Care Delivery For Our Nation's Veterans, states that there were only 400 active agreements at 160 facilities, and most alarmingly, only 30 are actually working.

We believe that better services for beneficiaries from sharing agreements can only be realized if there is total commitment from the highest levels of each Department. The respective Secretaries must shine a spotlight, so to speak, on DOD-VA health care resource sharing. Their delegates must understand that they have the authority to identify and enact mutually beneficial agreements, and in fact are expected to act. Failure to act on identifiable and beneficial agreements should be met with swift Departmental and Congressional action.

The VFW cannot emphasize enough our conviction that any sharing agreement between DOD and VA must not adversely affect the range of services, the quality of care or the established priorities for care provided by either agency.

Simply put, we will support only that which benefits veterans and active duty patients no matter what cost savings may result as a consequence. Further, we insist that any savings realized as a result of sharing agreements be immediately reinvested into the respective health care systems without offset from Congressional appropriation. This is vital in that both systems are in dire need of additional funds.

For all their differences, we believe there are a number of areas where DOD and VA can work together to improve cost sharing as well as the range of services and the quality of care provided to our nation's armed forces, military retirees and veterans. In fact, they already are in certain areas. The VFW supports expanding and enforcing these existing types of agreements, while encouraging both Departments to continue to identify them.

In addition, we are aware that both Departments are considering the process and means of realigning their assets to enhance the way they do business. And we are referring, of course, to the upcoming BRAC for the Department of Defense as well as the VA CARES process. It is absolutely essential that these respective De-

partments keep these processes in mind as they go about their business.

Toward conclusion, I would also indicate that we, at the VFW, also oppose the forced choice for military retirees of VA or DOD health care. It is simply wrong, and it is medically speaking not really practicable, and we strongly oppose the proposal to have a $1,500 copay.

Mr. Chairman, thank you very much. That concludes my statement.

[The prepared statement of Mr. Cullinan can be found in the Appendix on page 98.]

Mr. MORAN. Thank you for your statement. Mr. Thomas.

Mr. THOMAS. Mr. Chairman, members of the committee, it is indeed a pleasure to be here before you today in this historic joint session, and we thank you for inviting us.

The Paralyzed Veterans of America (PVA) is somewhat concerned that a potential merger of the two health-care systems, driven primarily by potential cost reduction efforts, could result in a potential negative effect on the delivery of services for both beneficiary populations.

As Chairman Smith pointed out earlier today, the VA suffers from chronic underfunding. This year alone, the President's budget proposal, as Chairman Smith stated, is approximately $3 billion short. This has been this way for several years. In the first session of this 107th Congress, there were many new initiatives passed and became law for veterans. However, the appropriators have not seen fit to allocate any funds to support those initiatives. The Veterans Millennium bill that was passed in 1999, the long-term terror aspects of that bill have not been fully implemented. And why? Because there is no money in the VA system to do that.

PVA supports maintaining access to the VA health care system for all veterans, not just some. We also support the expansion of the Veterans Health Administration (VHA), and DOD sharing agreements, providing they are accomplished in a careful, methodical manner and in the best interest of all populations served. Any potential savings through sharing agreements must be supported by facts and rigorous analysis. Veterans and DOD beneficiaries deserve a Federal health care system that focuses on providing first-rate, accessible and compassionate services.

VA is the second largest financial supporter of education for medical professionals and the nation's most extensive training environment for health professionals. Last year alone, VHA affiliations with academics trained more than 85,000 clinicians. These academic affiliations bring first-class health care providers to the service of America's veterans.

The opportunity to teach attracts the best practitioners from the academic medical area, along with state-of-the-art medical sciences to the VA. Any coordination or cooperative arrangement made between the VA and DOD systems must not impinge on this specialized mission. In a like manner, the VA's unique research program must be maintained.

VA typically treats a population of older Americans, chronically ill and disabled veterans. As the nation's leader in such specialized services as blind rehabilitation, spinal cord injury, and mental

health, the VA provides the full continuum of health care services to veterans, including nursing homes and assisted living in long-term care facilities, to adult daycare and geriatric services.

VA prosthetics and research provide services and innovations unmatched in any other health care environment. These missions, too, are unique to U.S. medicine and could be threatened if some form of merger were to take place between VA and DOD.

Typically DOD medical facilities treat younger and much healthier patients. DOD facilities have expertise in prenatal, obstetrics and pediatrics for family members and our active duty military. When DOD beneficiaries acquire conditions typically treated by the VA, they are discharged and therefore become eligible for enrollment as VA beneficiaries. This is another example of how the two Departments do work together, but also why in fact they are very unique entities.

PVA recognizes there are many areas for VHA and DOD to share that could provide significant advantages, such as joint purchasing of pharmaceuticals, supplies and equipment. At the present time, there are over 50 joint contracts for pharmaceuticals between DOD and VA.

Additionally, there is a need for improved information exchange between the two systems. Here, again, this was pointed out earlier today. Within DOD itself they have many systems that do not talk to each other. We do not believe that there are any savings to be gained by forcing patients of one system to use the facilities of the other.

While many local arrangements work to improve access and convenience of veteran and DOD beneficiaries, we do not see any need for a national initiative to force increased cross-system patient care. Beneficiaries of both systems must maintain the full range of health care choices.

We believe that where local situations favor sharing, such as the recent agreement that was pointed out, the Great Lakes Naval Center and North Chicago, by all means we should take advantage of these situations. VHA and DOD should continue their efforts to improve information exchange and to cut costs by combining their purchasing power in the marketplace.

Enhanced access to high quality health care services for active service members, veterans, retirees and family members of active or retired service members, as provided by law, should be a common goal. We certainly have a responsibility to see that resources are used wisely to achieve that goal. Thank you, and I will be happy to answer any questions.

[The prepared statement of Mr. Thomas can be found in the Appendix on page 94.]

Mr. MORAN. Mr. Thomas, thank you. Dr. Snyder.

Dr. SNYDER. Thank you, Mr. Chairman. I appreciate you calling me. I have a 2 o'clock Military Installation Subcommittee meeting upstairs that I want to go to. I do not think I have any specific questions but just a few comments.

I thought, Mr. Washington, you captured the standard, well, that whatever we do it needs to result in the same level of service, hopefully with some cost savings or efficiency or maybe not any savings

but a greater level of service for whoever we are serving. I think that is the standard that everyone wants.

And it particularly was brought home by Mr. Thomas. The specialty clinics are very important, and there is experience over decades in the VA system with regard to amputees and paraplegics that are just not found anywhere else in the country. And literally some people having attended those clinics for 40 and 50 and 60 years is nothing to ignore.

You heard the comments earlier as we talked about culture, and, Mr. Robertson, your thought about what you mean as buy-in. I mean all the legislation and committee oversight and hearings, I mean these are big systems, and they are certainly a way, if there is not buy-in really at all levels, there is just a natural resistance and inertia that is going to block it.

I think Mr. Cullinan referred to total commitment. That was your response, and clearly that is not what we have seen. I thought Dr. Wilensky brought that home too. What can we do on this side and what can you all do on that side to nudge this systems along to buy-in and total commitment?

Just the last thing I would say, I think your role is a very important one here as far as being part of this monitoring of the systems. I thought some of the specific suggestions you made, just in the course of your discussions with the Administration, it reminds me a little bit of when people come to me about issues and how to impact an issue.

I always suggest to them, you know, whatever your group is, whether it is to protect whatever you are trying to do, divide yourselves up into political races and have somewhere in the campaign, you have two candidates running against each other, have your folks ask the candidates, "Hey, I want to talk to you about such and such after the election." Now, one of them is going to win and you have planted the seed, but the same is true for nominees to these offices for the folks that you work with it is asking the question, "How do you see this issue of resource sharing?" I think your role is probably every bit as important as ours.

But thank you for attending, and I am sorry I have to leave to catch the 2 o'clock hearing. Thank you. Thank you, Mr. Chairman.

Mr. MORAN. Thank you, Dr. Snyder. Mr. Wilson.

Mr. WILSON. Thank you, Mr. Chairman, and I would like to thank the veterans' organizations for being here today. You give a very extraordinary input of the people who actually receive the services, and it means a lot to me. And in particular I have been a member of The American Legion now for over 25 years. And so I appreciate what you do.

And then I want to particularly commend Mr. Washington in that he and I share the same hometown of the holy city of Charleston, South Carolina. And so it is a great bond to have with you, and I look forward to—I am a newcomer. I have been in office now just a little over 2 months, and so this has really been very helpful to me, Mr. Chairman. Thank you for conducting the meeting, and I look forward to working with you in the future.

Mr. MORAN. Mr. Washington and Mr. Thomas, it seems to me that your testimony in particular points out cost savings that can occur in procurement issues, pharmacy, but a real reluctance to

share the responsibility for the providing of direct health care services to veterans and members of our military. Is that an accurate brief summary of your thoughts?

Mr. WASHINGTON. Yes, sir. The only thing that we are worried about is access of care for our beneficiaries. So whatever cost sharing effect that it would have that would bring the best quality of care, that is what the coalition main objective is, is that we provide the best care that we can.

Mr. MORAN. The follow-up to that question is that the focus that you are suggesting, I think, in that thought is that this is about potentially saving money, and I think clearly that any money we save, I certainly would agree with you, needs to be put back into the system of providing health care. I think that is a clear—I do not think any of us would want to head down this path if the outcome would be otherwise.

But is there not improvement in services that can be had beyond the cost savings? I mean cost savings certainly is an important thing, but I want to know whether you think we would be doing something that for many of those that we are trying to serve would have enhanced opportunities for general health care services as compared to the cost savings that might accrue to the system. And I would be glad to have any response from any of the members of our panel. Mr. Cullinan?

Mr. CULLINAN. Mr. Chairman, I would like to respond to that. Our main focus, and I am sure it is a shared focus as well, is that what we want to come out of this is a greater array of services, greater quality health care provided to veterans and active duty military, as well as much greater accessibility. I think when you hear the term cost savings, the thinking is that indeed the money would have to be plowed immediately back into this system. And, additionally, by working together, VA and DOD should be able to provide more, better and make it easier to get to.

Mr. ROBERTSON. Mr. Chairman, one of the things that was really kind of a shock to me was when they did the BRAC, the initial BRACs, health care was not even a criteria that they were looking at. They lost over half of their medical facilities due to BRAC. And you wound up having military communities that had retired around a base and health care was always going to be there, always going to be there.

Well, guess what? It is not there. And these folks are finding themselves, military retirees who are entitled to health care after they finished their 20 years, struggling, trying to find a place to go. And in many places, the VA was close enough so they would be able to take care of them.

But this brings on one other issue, is if you have clinics that are right now, one is underserved and the other one is overserved, I mean that is a no-brainer. But yet you do not see those changes taking place. It is just like the example that they gave about the distribution of pharmaceuticals in South Carolina.

The things that seem so obvious are not being done. And I mean this is where leadership comes in. And I firmly believe, and The American Legion firmly believes, that it starts with the top and goes down. If it is not a command concern or command interest, if

it is not being driven from the top and people being held accountable for not doing it, we will continue to maintain status quo.

Mr. MORAN. Mr. Thomas?

Mr. THOMAS. Yes, sir. I would like to make one little comment. One of the reasons why we kind of hedge a little bit on stating the full continuum of sharing, if you will, is because of the specialty clinics that the VA has. As you pointed out, in some areas it is unparalleled within U.S. medicine.

A typical example of something that happened recently that was pointed out at a meeting I was yesterday. During the floods in Texas earlier this year, the only hospital that was left in operation in the entire area was a VA hospital. All of the civilian hospitals and military hospitals were out of commission. And someone had to come in, a lady in labor coming in to have a child delivered. And this VA doctor had never delivered a child before. So he was literally on the telephone with an obstetrician across town on how to deliver this baby.

And this goes back to what I pointed out is that within the DOD system they have those specialties; they do it all the time. The VA does not look into that area. It does not mean they cannot, but it would require a considerable amount of cross-training.

Mr. MORAN. Well, we all bring our own perspectives from home to Washington. I bring a perspective of a large congressional district, very rural, no VA hospital, no military installation. And I am trying to think of examples, and I would think they would exist across the country, although perhaps not in my state, where there is one or the other that makes health care services much closer to home. And it seems to me that that has, particularly with the age of our veterans, it has certainly been a theme of mine is trying to bring services to the places that our veterans actually live.

And the point that Mr. Robertson makes about the BRAC seems to me to be such a valid one; we make decisions about where we retire to. I have many constituents who would love the opportunity to retire right where they live today, but health care is someplace else, and I look forward to trying to sort through this to see if this is not at least part of the solution of bringing services closer to home, at the same time recognizing that the VA has tremendous expertise, as Mr. Thomas points out, that we very well may want to utilize to preserve and improve the quality-of-life of members of the military, for example.

And when you think about the real nature of what this business is all about—improving one's life and saving lives—it is hard to draw barriers where you could say this person is in and this person is not simply because they are either not—I guess because they are not yet retired.

And so I guess the other thing I would raise with you all—my time has expired, although I do not know that Mr. Evans will complain—the idea of TRICARE and the role that it could or should play in this debate and why it has not provided more access and opportunity despite legislative efforts in the past.

So as this issue moves on, I think there will be a number of us who would like to submit questions to you for your suggestions about what we can do legislatively or what needs to happen in regard to TRICARE to implement decisions that were made several

years ago. Mr. Evans, be happy to have you question the panel and summarize our day's hearing, if you would like.

Mr. EVANS. You have done a great job. I was thinking I was going to yield to you. But, no, I do not have any questions at this time.

Mr. MORAN. I appreciate very much the ranking member being with us throughout the day and appreciate the time that you all have taken. We will have follow-up questions, and we would ask, as Mr. Snyder has previously asked, that they be answered in a timely fashion. And I am told that Mr. Snyder's questions for the Administration have been so timely responded to, as of today he has an answer. So it does help to ask more than once, apparently.

Again, appreciate the testimony of this panel and our previous panels as well and look forward to pursuing this. I greatly value the willingness of Chairman McHugh, who I have admired since I came to Congress, as a very intelligent, diligent member, I am grateful for his willingness to look at opportunities for our two committees to cooperate.

And, as I said in my opening remarks, I think that circumstances we face today in the war on terrorism is a great opportunity for us on the VA Committee who look after veterans after they return from service and those who are on the DOD, on the Armed Services Committee, carrying about those who serve currently, that they are very much blended. And the consequences of failing to take actions during service have tremendous consequences upon return of those men and women home.

So I would only, once again, commend Mr. McHugh for his willingness to work with us and, again, thank you for the afternoon. We are adjourned.

[Whereupon, at 2:20 p.m., the subcommittee was adjourned.]

APPENDIX

MARCH 7, 2002

PREPARED STATEMENTS SUBMITTED FOR THE RECORD

MARCH 7, 2002

OPENING REMARKS OF CHAIRMAN MCHUGH

The joint hearing on VA–DOD Health Care Sharing will come to order.

Today's hearing is very different from others in my experience as chairman of the Military Personnel Subcommittee in that it brings together two subcommittees from different House committees for a common purpose. That purpose is to provide a basis for deciding what joint legislative action, if any, is needed in the short term to facilitate improved, mutually beneficial health care sharing between the Department of Defense and the Department of Veterans' Affairs.

The fact that the two subcommittees have joined in a common purpose should be a strong signal that we are not satisfied with the current extent of sharing, and have serious questions regarding the commitment of both departments to removing the often identified barriers to improved sharing.

Why, twenty years after enactment of broad authority to enable DOD–VA sharing, do the two departments and the health care beneficiaries they serve find themselves:

- With sharing initiatives whose success is largely related to the ability, perseverance, and personality of local VA and DOD health care leaders willing to fight their way through and around the obstacles that block their success?
- With sharing initiatives whose value constitutes a miniscule amount compared to the $35 billion annual combined health care budget of both departments?
- With DOD and VA health care delivery, workload, beneficiary information, management, cost accounting and financial information systems that remain incompatible and unable to communicate, despite numerous studies over the years pointing out these inadequacies?

And why, 20 years later, do the two departments seem to be without either a common purpose or joint vision for what sharing should achieve, and without a metric or means for how sharing success should be measured?

I am heartened to hear that not only has the Administration made closer DOD and VA coordination a major goal, but also that senior leaders in both departments recently announced their reinvigorated efforts to improve sharing.

We here are fully willing to assist the Administration and both departments to sustain that newly found vigor. However, I know enough about previous statements regarding renewed commitments to DOD–VA sharing to understand that sustained joint action did not often follow.

Given that history, I believe that many Members on these two subcommittees are skeptical about the prospects for improved shar-

ing if the initiative for the improvement is left entirely to the discretion of the two departments.

However, before either subcommittee takes directive legislative action, or we jointly take action, I believe we need a better understanding of a range of issues. That's why I look forward to the testimony of all our witnesses today.

REVIEW ADMIN AND PROCEDURAL GUIDELINES

Before I recognize the first witness today, I would like to make just a few administrative remarks. Because this is a joint hearing between the Health Subcommittee of the Veteran's Affairs Committee and the Military Personnel of the Armed Services Committee, Chairman Moran, Mr. Filner, Mr. Snyder and I have agreed on guidelines that we hope will allow the hearing to proceed in an orderly fashion and allow each member attending today the chance to get their questions before the witnesses. Our respective committee staffs have met with your legislative assistants earlier this week to discuss these guidelines and to provide you with the background memoranda.

We have eleven witnesses and three panels. The key is that we need to give each witness the chance to present his or her testimony, and each member an opportunity to question the witnesses. Therefore, we have agreed to impose a five minute rule on witnesses' opening statements and on members. I remind witnesses that we desire that you summarize the high points of your written testimony and that your full written statements will be made a part of the hearing record.

At the end of the government panel, I will yield the Chair to Congressman Moran, Chairman of the Health Subcommittee.

Finally, a number of statements have been submitted for inclusion in the record from organizations who wanted to testify, but who could not because of our time limitations. I ask unanimous consent that these statements be entered in the hearing record.

Before I introduce the first witness, I will recognize Chairman Moran, followed by Congressman Vic Snyder, the Ranking member of the Military Personnel Subcommittee and also a member of the Health Subcommittee. Congressman Filner will then be recognized for his opening statement. Finally, I will recognize Rep. Evans, Ranking Democrat on the Veterans' Affairs Committee, for his remarks.

STATEMENT OF THE HONORABLE VIC SNYDER

Thank you, Mr. Chairman. I would also like to welcome Dr. David Chu, Dr. Leo Mackay, Nancy Dom, Gail Wilensky, and the representatives from our veteran and military service organizations who are here today to assist us in our continued efforts to improve and enhance the current state of DOD's and VA's resource sharing efforts.

DOD and VA have two very distinct and different missions—protecting our national security and serving our veterans-however, health care is an area in which increased opportunities for sharing could improve the quality of services to our beneficiaries and reduce costs to the Departments.

Less than eight months ago, Rear Admiral Clinton, the Acting Assistant Secretary of Defense (Health Affairs) and Dr. Garthwaite, Undersecretary for Health, testified before this subcommittee on the status of sharing between these two Departments. At that time, it was interesting to note that the two Departments did not even agree on the number of current sharing agreements in place. DOD's testimony was that

there were 717, while VA indicated that there were 834. I hope that the VA's response to the subcommittee's written questions are not indicative of the efforts being made to improve resource sharing activities—seven month for a reply is rather excessive.

I look forward to hearing from our governmental witnesses on what has been done to date to remove barriers that impede DOD–VA sharing. Have the Departments identified opportunities to improve business practice and infrastructure utilization? Have they identified ways to address problems that were previously raised with respect to information sharing or establishing adequate billing systems? What role can and should VA play in the next generation of TRICARE contracts? Have the systems identified the impediments to sharing and can they be addressed by the agencies or does it require Congressional leadership?

We have had previous Congressional initiatives, GAO reviews, a VA–DOD Executive Council, a Congressional Commission, and now a President's Task Force tasked to specifically review the two Departments to improve the health care delivery for veterans. I hope today's hearing will focus on what we have accomplished to-date and how we can and should move forward to encourage greater and more efficient resource sharing agreements.

Thank you, Mr. Chairman; I look forward to working with all parties as we continue our oversight into DOD–VA resource sharing.

STATEMENT OF HONORABLE LANE EVANS, RANKING DEMOCRATIC MEMBER, HOUSE COMMITTEE ON VETERANS AFFAIRS

Public Law 97–174 (1982) has existed for two decades and provides the authority for sharing initiatives between VA and DOD. This law required the Under Secretary for Health of the Department of Veterans Affairs and the Assistant Secretary of Defense for Health Affairs to form an interagency committee to oversee opportunities for sharing the medical resources of VA and DOD. It directs the senior leadership of each agency to jointly establish guidelines for the sharing of medical resources, to include provisions for cooperative sharing agreements, by health care facilities of their respective Departments. The relative success of sharing initiatives between the VA and DOD has varied greatly—opportunities are too often missed.

My focus on enhancing sharing opportunities will address the creation of management systems that facilitate sharing and provide managers with the tools and incentive to exploit reasonable sharing opportunities and get the job done. Intelligent use of sharing opportunities can both enhance services and reduce overall costs. Congress must not micromanage this effort, nor mandate sharing quotas, nor embark on demonstration projects without first determining how those projects, after years of seeking varying degrees of sharing, cooperation, and management system integration, will extricate themselves from the demonstration and rejoin the standardized management system that will evolve over time. How will service members and veterans fare when they receive treatment at a nonsharing facility?

Effective VA/DOD sharing opportunities are discovered and engaged by successful managers and used in successful organizations. With the 1982 law came the authority for sharing, not the incentive for sharing. Leaders who use sharing to enhance services to veterans, service members, and their families deserve meaningful recognition and those "managers" who exert minimal effort to discover opportunities deserve minimal recognition.

Another opportunity is before us today that would have significant impact on the DOD and tremendous impact on VA in the out years. This opportunity is passing us by with hardly a nod from Administration leadership.

The DOD and the VA are each undertaking major projects using information technology as a strategic tool to support their missions. Two databases, one in each Department, are being formed, modified, and groomed for the mission of each agency. But those missions are linked regarding people. Why is there not more cooperation among the Departments regarding DOD's Defense Integrated Management Human Resources System and the VA's "One-VA" overarching information technology architecture? The impact of data transfer would be of great benefit, allowing VA to receive accurate data, and allow the DOD many opportunities in research, etc. Unfortunately, there is almost no coordination between these IT project managers. The mere standardization of common data fields would be of great benefit.

The relative failure of DOD/VA sharing is not a result of the 1982 law, it is a failure of managers to seek out meaningful sharing opportunities. We must not overreact.

OPENING STATEMENT OF LUIS V. GUTIERREZ

Chairman McHugh and Chairman Moran, I am pleased that we are having this joint hearing today. A joint hearing between our two subcommittees is unprecedented and I look forward to the testimony of the panelists assembled here who will share their insights and expertise with regard to health care sharing by the Department of Defense (DOD) and Department of Veterans' Affairs (VA).

I understand that we will hear about the advances that the DOD and VA have made with regard to collaborating more closely over the years, and what additional resource sharing between them is needed. But, before we get focused on the details of this process, I would like to remind everyone here that our goal is not to save the government money, but to figure out creative ways to maximize the dollars spent on behalf of deserving military service members and veterans.

Veterans in my district are experiencing first hand the efforts of the Department of Veterans' Affairs to save money. In an effort to consolidate hospital services and trim the budget, in-patient hospital services at Lakeside Hospital in Chicago will be closed. This will mean fewer full time employees, increased waiting time for services, longer travel distances for veterans and the loss of continuity of care for patients. Furthermore, veterans in my district felt shut out of the CARES process that resulted in this decision and NO veteran should ever be put in this position.

As we consider how to consolidate services between the Department of Defense and the VA, I hope that our panelists will specifically address how the stakeholders—veterans and military service members themselves—are engaged in all levels of this process. As we discuss the $98.3 million that has been saved on pharmaceuticals as a result of closer cooperation between VA and DOD, I hope we will also hear the reasons why—if this process of combining resources is actually to maximize dollars for the benefit of deserving veterans—*why* there was a $5 increase in veterans' copayments for prescription drugs.

I thank the panelists for being here today and I look forward to your testimony.

STATEMENT OF THE HONORABLE SOLOMON P. ORTIZ

I come before you today to express my continued adamant support for the U.S. Naval Hospital-Corpus Christi to become one of the three demonstration sites where the Department of Veterans Affairs (VA) and the Department of Defense (DOD) will fully integrate operations as directed in the Fiscal Year 2002 Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations bill, which is now Public Law 107–73. This mandate directs the VA and DOD to submit a credible plan by September 1, 2002, for no less than three demonstration sites, and I fully support locating one of the three sites at the Naval Hospital-Corpus Christi.

I have remained in continued contact with both VA personnel and the U.S. Navy to support this very important objective. Specifically, I have met with VA Secretary Anthony Principi to discuss this issue, as well as with Vice Admiral Michael Cowan, Surgeon General of the Navy, and a number of other Veterans Affairs and DOD personnel. I also testified before the Appropriations Subcommittee on Veterans Affairs, Housing and Urban Development, and Independent Agencies, last year to express my deep concern, and have strong support from Congressman David L. Hobson, who sits on the same subcommittee and is also chairman of the Military Construction Appropriations Subcommittee.

While in Congress for the last 20 years, my continued efforts to bring more comprehensive veterans health care services closer to the U.S.-Mexico border in South Texas have led to little progress, and my frustration is mounting, especially when I understand that there are other VA hospitals in the country where patient numbers are decreasing while the population of veterans in South Texas is increasing. Therefore, I respectfully request that the Naval Hospital-Corpus Christi be given full consideration as one of the three VA–DOD integration demonstration sites.

Thank you very much for allowing the time to hear me today, I look forward to working with the committee on this very important matter.

STATEMENT OF THE HONORABLE CHRISTOPHER H. SMITH, CHAIRMAN, HOUSE COMMITTEE ON VETERANS' AFFAIRS

Chairman McHugh, Chairman Moran, Ranking Member Snyder, Ranking Member Filner, I want to thank all of you for working together to make today's hearing a reality. It is a pleasure to be with you this morning to share my views on ways to improve the cooperation and collaboration between the Departments of Veterans'

Affairs and Defense in fulfilling their health care obligations, and specifically on the legislation that I have introduced, H.R. 2667, to further this goal.

At the outset, let me say how much I appreciate the support of Armed Services Committee Chairman Bob Stump, the former Chairman of the Veterans' Affairs Committee, in moving ahead with today's hearing. His leadership, and your leadership, Mr. Chairman, in working with our Committee, has been exemplary. You, Chairman Moran, Mr. Snyder and Mr. Filner are truly demonstrating the advantages of Committees working together to benefit the men and women who are serving, have served or will serve our Nation in the armed forces.

As Chairman of the House Committee on Veterans' Affairs, I have the privilege of working everyday to improve the quality of life for our Nation's 25 million veterans and their families. Given the tight fiscal and budgetary realities that face our Federal government, if we are to continue providing quality health care for all those who need it, we must make the best use of those resources that are currently available. Inefficiencies and duplication not only waste taxpayer dollars, they short-change military personnel, retirees, and veterans seeking health care.

This year, the Departments of Veterans Affairs and Defense will spend nearly $40 billion combined on health care for current or former military personnel and their families. Yet despite this enormous sum, there is still not enough to meet all of their health care needs. The Federal Government must find ways to maximize efficiency and minimize unnecessary, duplicative services that drain dollars from their primary purpose—providing timely, quality health care to present and former service personnel and their families.

Mr. Chairmen, I strongly believe that the Federal Government must aggressively seek to increase resource sharing between these two massive health care systems, whenever and wherever feasible. Although Congress has made efforts in the past to promote specific sharing, the results have been modest at best.

For example, we authorized the Mike O'Callaghan Federal Hospital at Nellis Air Force Base outside Las Vegas. It is a 96-bed Air Force-managed hospital with 52 VA-dedicated beds. This facility still has significant potential to serve as a model for sharing, but the VA and the Air Force were required to maintain separate budgets, financial, human resources, patient care records and data management systems. Combined, their annual budgets are over $46 million, yet they effectively operate as two independent Federal facilities within the same walls, with needless duplications of systems management and services, as well as inefficient use of resources.

Despite being co-located, they maintain separate pharmacies, one for veterans and the other for Air Force beneficiaries. Both the VA and the Air Force also maintain separate intensive care units, surgical operating rooms and support facilities and staff. Such duplication of facilities and services wastes funds that could be used to improve delivery of health care to both veterans and military communities.

In Albuquerque, New Mexico there is a VA-Air Force partnership between the VA Medical center and Kirkland AFB Hospital that provides admitting privileges to Air Force physicians. The relationship between the VA and Air Force at these facilities is a good beginning to sharing.

However, despite their promising sharing relationship, there remain many untapped areas where new efficiencies could be achieved in Albuquerque. For example, the Air Force and VA needlessly maintain separate dental clinics, central dental laboratory functions and separate supply chains. Also, the Air Force continues to maintain a management presence as though it were still operating as an independent hospital facility, even though most of its activities duplicate those of the VA.

Some facilities that are close neighbors—essentially co-located facilities—could become joint facilities, thereby almost certainly reducing administrative costs as well as staffing needs. With such savings, additional resources could be invested in patient treatment and technological improvements. For instance, at the San Diego VA Medical Center, the fiscal year 2001 budget is $202 million, and at the Balboa Naval Medical Center, the fiscal year 2001 budget is over $338 million. Although these facilities are only a few miles apart, no clinical sharing occurs between them. Does anyone doubt that money could be saved by reducing duplication of services, particularly expensive testing equipment and facilities?

For too many neighboring VA and DOD health facilities, separate management and operations are the only way they conceive of doing business, even when another Federal medical facility, also supported by public dollars, may be little more than a stone's throw away. I am convinced that this separateness is the result—at least in part—of deeply ingrained habits, entrenched organizational cultures and long-standing turf battles.

Perhaps the most illustrative example of the failure to pursue sharing agreements that we have seen recently is in Charleston, South Carolina, home to the Naval Hospital Charleston and the Ralph H. Johnson VA Medical Center. During a visit

last year by Veterans' Affairs Committee staff, the Naval Hospital's Director, in the course of discussing the issue of resource sharing, also talked of the difficulty they experienced in recruiting and retaining pharmacy technicians to meet the demand for approximately 500 mailout prescriptions every day.

What the Navy did not see is literally right across the street: a VA Consolidated Mail Outpatient Pharmacy facility, one of eight nationwide, which produces 52,000 mailout prescriptions daily for eligible veterans. When our Committee staff and the Navy personnel met with the director of the VA facility, he told us that he would have little problem whatsoever in fulfilling an additional 500 prescriptions, which would increase the workload by less than 1% of their daily volume.

That was last April. Today, almost one year later, there has been no change. The new executive staff at the Naval Hospital seems unaware of our staff's visit, or of the possibility of utilizing the VA pharmaceutical facility. Nothing has changed.

These are just a couple of the many lost opportunities for resource sharing. I would commend to your attention a staff report published by the Committee on Veterans' Affairs that documents these, and other examples of VA and DOD facilities that have failed to take advantage of the benefits that come from sharing health care resources.

To move beyond the status quo, last July, I, along with Veterans' Affairs Committee Vice Chairman Mike Bilirakis and others, introduced H.R. 2667, the "Department of Defense—Department of Veterans Affairs Health Resources Improvement Act of 2001." This legislation takes another step towards fulfillment of the goals set out almost twenty years ago by Public Law 97–174, the "Veterans' Administration and Department of Defense Health Resources Sharing and Emergency Operations Act of 1982."

Our legislation would establish five health care sharing demonstration projects in five qualifying sites across the country. The purpose of the demonstration projects would be to reward those who are not daunted by current obstacles that prevent sharing where it is clearly possible.

H.R. 2667 would, to the extent feasible, require a unified management system to be adopted in the five demonstration sites to the extent feasible. A unified system would look at ways to eliminate differences between the budget, health care provider assignment, and medical information systems. At the present time, the two Departments' information systems are still incompatible, and so this legislation would also encourage greater software compatibility. By making such systems communicate better, we can better ensure continuity of care, equality of access, uniform quality of service and seamless transmission of data.

In addition, the demonstration projects would provide for enhancement of graduate medical educational programs at the five sites. This will create a great opportunity for health professions students by giving them a combined exposure that has not been available to them before. It would also bring a better awareness and understanding of differences in the two beneficiary populations for new and experienced health care professionals alike.

Mr. Chairmen, H.R. 2667 is a realistic framework for taking direct steps to improve sharing, and I would urge both Subcommittees to consider moving rapidly on this legislation.

As the war on terrorism continues, and casualties occur, we are reminded once again of the absolutely vital role that our servicemen and servicewomen play in defending freedom, and of the gratitude and obligations that we as a nation owe them. At this very moment, in the frigid mountains of Afghanistan, they are making sacrifices on behalf of all Americans; some will make the ultimate sacrifice for their country.

In return, we must fulfill our obligation to provide the best and most efficient health care for them and their families, now, and after they return. I am convinced that this will be enhanced if if we truly begin combining—when and where it is appropriate—the health care resources of the Departments of Veterans Affairs and Defense for the benefit of our soldiers, sailors, airmen and marines—past, present and future.

STATEMENT OF DR. LEO S. MACKAY, JR., DEPUTY SECRETARY DEPARTMENT OF VETERANS AFFAIRS

Thank you for the opportunity to speak to you this morning about the status of coordinating health care resources between the Department of Veterans Affairs (VA) and the Department of Defense (DOD). As you know, the President has identified expanded collaboration between the VA and DOD health care delivery systems as a top priority for his Administration, listing improved interagency coordination be-

tween VA and DOD as one of his top management agenda items to benefit both VA and DOD beneficiaries. The President further demonstrated his personal commitment to veterans and military retirees by signing an Executive Order on Memorial Day 2001 establishing the President's Task Force to Improve Health Care Delivery for Our Nations Veterans (PTF).

You will hear more about the PTF this morning from Dr. Gail Wilensky, Co-Chair of the President's Task Force; however, I want to express the Department of Veterans Affairs strong commitment to supporting the activities and deliberations of the PTF as the Members review barriers to VA and DOD cooperation and identify opportunities for improved partnerships. We view the work of the PTF as vital to shaping our future relationship with DOD and look forward to receiving the interim report from the PTF this summer and the final report in March 2003.

There is no question enhanced collaboration between VA and DOD has the potential to improve services to our respective beneficiary populations, increase government efficiencies by decreasing the costs of providing bifurcated health care services and veteran's benefits to DOD and VA beneficiaries, and improve utilization of our health care facilities. Over the years VA and DOD have been actively engaged and have enjoyed successes; however, much work remains to be done and VA welcomes the opportunity to expand our partnership with the Department of Defense.

To accomplish the goal of improving coordination to achieve greater benefits for our beneficiary populations, the Departments have established two joint executive councils to explore areas where we can improve or enhance sharing activities. The VA/DOD Health Executive Council is an ongoing collaborative venue between the leadership of the Veterans Health Administration and the DOD Health Affairs. This council has been reinvigorated in the last year through establishment of new goals, work groups, and accountability. Based on the successful Health Executive Council model, the VA/DOD Benefits Executive Council was recently established to provide an official forum for senior level interaction between the Veterans Benefits Administration and the DOD Office of Force Management Policy.

To increase the substantive actions taken by our two Departments and demonstrate leadership commitment to providing our beneficiaries with a seamless transition from military to veteran status, Dr. David S.C. Chu, Under Secretary of Defense for Personnel and Readiness, and I have recently begun to hold joint meetings of the Executive Councils to ensure that we receive regular updates on joint strategic planning activities and initiatives, provide guidance and policy direction on collaborative initiatives, and ensure that Department level administrative issues are not overlooked in individual Executive Council discussions. We plan to hold these joint meetings on a quarterly basis.

I was privileged to host our first joint meeting on February 11, 2002, at the Department of Veterans Affairs. During our inaugural meeting we had an opportunity to focus on several key issues that have direct impact on the future success of our VA/DOD collaborative initiatives. The specific areas of discussion included: standardized billing and reimbursement rates; joint procurement initiatives; computer based patient medical record initiatives; Defense Enrollment Eligibility System (DEERS); coordination of capital Investments; and planning for the receipt of the recommendations of the Presidential Task Force to Improve Health Care Delivery for Our Nation's Veterans.

While much work remains to be done, it is important to note that VA and DOD executive leadership at the National, regional, and local levels have been working jointly for several years to improve and expand sharing with significant accomplishments to our credit. Nationally, VA and DOD have made progress in the joint development of clinical practice guidelines. VA has taken a leadership role in the promotion of patient safety and DOD has benefited from our experience and is adopting aspects of our program. We are saving significant taxpayer dollars through joint procurement efforts, primarily in pharmaceuticals. We are pursuing better transmission of health data between the two agencies, improved coordination of capital facilities planning and use, and improved resource sharing between our regional organizations and local facilities as well as increased VHA treatment of DOD TRICARE beneficiaries.

JOINT PROCUREMENT

Although we will need to engage in significant discussions to iron out potential implementation details, both VA and DOD have identified improved partnering for health care procurement as an action needed to ensure better coordination of DOD and VA services. Experience has clearly demonstrated that our combined purchasing power results in significant financial savings to both VA and DOD, allowing us to better utilize our budgets to the benefit of our respective beneficiary populations.

For example, VA and DOD entered into a Memorandum of Agreement (MOA) in December 1999 to combine the overall purchasing power of our two Departments and eliminate redundancies. The MOA has two completed appendices, one dealing with pharmaceuticals, the second, encompassing medical and surgical supplies. A third appendix covering high tech medical equipment is being finalized.

As part of the MOA, and in an attempt to reduce duplication between the two departments, DOD agreed to eliminate their Distribution and Purchasing Agreements (DAPAs) for pharmaceuticals and to rely upon VA's Federal Supply Schedule (FSS) for pharmaceuticals by late 2000. As a result, DOD's DAPAs were eliminated in January 2001 for all pharmaceuticals that are available under VA's FSS program. Thus, in FY 2001 DOD purchased $1 billion dollars of pharmaceutical items through its own prime vendor program, using FSS pricing. Utilizing its own prime vendor program, VA purchased $2.5 billion of pharmaceutical supplies. This same process, converting DOD DAPAs to VA's FSS program, is being utilized for medical and surgical supplies. The first data feed was completed in December 2001 and conversion is expected to be completed by December 2002. Once the appendix for high-tech medical equipment is signed, contracting responsibilities will alternate between the Departments and will allow both Agencies to place orders against the resulting contracts.

Another important area of the MOA focuses on joint procurement of pharmaceuticals. As of February 20, 2002, there were 57 VA/DOD joint contracts for pharmaceuticals; 35 additional joint contracts pending award; and 30 proposed joint contracts waiting to be processed. The estimated cost savings in FY 2001 for both Departments from these contracts totaled $98.3 million ($80.1 million for VA and $18.2 million for DOD). These savings were obtained from 43 contracts. We have not yet received the actual cost savings figures for the contracts awarded to date during this fiscal year, but believe savings will continue to grow.

To further improve collaboration and reduce health care costs for both departments, VA is proposing legislation to allow DOD to directly utilize the VA Revolving Supply Fund for medical supplies, equipment and services procurement. We believe that enactment of this provision will facilitate cooperative management of significant VA/DOD acquisition programs.

INFORMATION TECHNOLOGY

The development of compatible information technology systems may be one of the most important areas that VA and DOD address in an interagency manner in the coming year. Both VA and DOD spend significant amounts of taxpayer funds annually on the information technology and information management programs supporting our two missions. Yet, in spite of our best efforts to date and the requirements of both departments for similar information over the life-cycle of a member of the armed services, incompatibility of VA and DOD information management and technology systems is one of the most frequently noted impediments to increased coordination between the two departments. This results in duplication of workload, promulgation of inefficiencies, inability to communicate critical data in an efficient manner, and increased paperwork for our veterans. We currently do not have a complete single repository of active service members' and veterans' health data that can be used to ensure continuity of care, improve health care delivery, and provide valid, reliable data for disability claims. DOD tracks all relevant information for active duty members and their families. However, when these individuals go to VA for medical or other services or benefits they must enroll at VA, often providing the same information already on file at DOD. We are now investigating the possibilities of using the DOD Defense Enrollment/Eligibility Reporting System (DEERS).

The improvement of information technology compatibility and establishment of an interoperable electronic patient record system top the VA/DOD coordination agenda of this Administration. With respect to information technology coordination and health data repositories or databases, specific actions are being taken through the VA/DOD Health Executive Council and are being monitored by senior department leadership through our Joint Executive Councils forum.

For example, the VA/DOD Health Executive Council Information Management and Information Technology Work Group manages the VA/DOD interagency Government Computer-based Patient Record (GCPR) program, recently renamed the Federal Health Information Exchange (FHIE) to better reflect the intent of the program. The goal of FHIE is to make DOD and VA medical data available to VA and DOD clinicians with the highest functionality at the lowest cost. VA and DOD are establishing a national repository under the GCPR/FHIE Project that allows for sharing of select DOD patient data at VHA locations. The transfer of DOD data to VA is in the testing phase. In this fiscal year, VA and DOD are developing a joint

business case and implementation plan to address the interoperability of GCPR/FHIE with CHCS II, DOD's new system in development, and VistA, VA's patient information system. Additional phases of this project will support DOD viewing of VHA information.

Other information technology sharing efforts already underway between DOD and VA through the VA/DOD Health Executive Council include: Health Insurance Portability and Accountability Act of 1996 (HIPAA) standards development; pharmacy initiatives; technology integration laboratories; VA/DOD Laboratory Data Sharing and Interoperability; and collaboration for a VA/DOD Consolidated Mail Order Pharmacy (CMOP) pilot.

While these ongoing efforts are significant and we hope to realize substantial progress through them in moving toward more seamless information transfer, we are continuing to explore additional opportunities for collaboration to improve delivery of care at the patient level and to better utilize taxpayer dollars. For example, DOD is establishing a national patient record using a Health Data Repository product from a commercial vendor. VA intends to pursue a comparable solution and has staff working with DOD on a regular basis. VA also intends to explore the potential with DOD to create a second phase to this effort that supports creation of government-owned repository architecture/software, not dependent on vendor technology. This architecture/software could also be used throughout government to create health care repositories that can easily share patient information.

Looking to the future, last fall VA, DOD, the Indian Health Service, and other agencies began to look at the potential for a substantially expanded health information system, entitled HealthePeople, whose purpose is to improve sharing of health information; develop and adopt common standards; seek appropriate opportunities for joint procurements and/or building of systems; work toward improved, model health information systems; and explore the potential convergence of VA and DOD health information software applications.

As we pursue the short, mid and long term goals of delivering health care and maintaining adequate medical records for our nation's military and veterans in a seamless fashion, it is important to recognize the magnitude of the undertaking and remain focused. The complexity and magnitude of the two health care delivery systems and their health information systems present a challenge in building health data repositories for each organization that can handle the large number of health records, appropriately ensure privacy and security, and support sharing of information. To address these unique challenges in establishing better linkage between the VA and DOD information management and technology, DOD and VA are currently considering separate data repositories to ensure privacy and security and to reduce the consequence of any failures. It is our expectation that both repositories will be operational before 2005, with common data standards to support retention of records from DOD and VA.

SHARING CAPITAL ASSETS

For a number of years, consideration of potential sharing with local DOD facilities has been part of VA's Major Construction planning process. As a result, several joint facilities are currently in operation. VA recently completed a review of capital asset infrastructure in the Chicago area and plans to complete reviews of needs for the rest of the country during the next two years. As we conduct these reviews we will involve DOD counterparts at both the local and national levels to assure that we do not miss opportunities to better serve our beneficiaries.

VA and DOD collaboration in the North Chicago area provides an outstanding example of the mutual benefit of interagency capital asset sharing. The Secretary of the Navy and I recently signed an agreement to transfer 48 acres of VA land at the North Chicago VA Medical Center to the Great Lakes Naval Training Center. The land will help the Navy modernize their recruit training facility and, in exchange for the land, the Navy has agreed to purchase electricity and steam from a VA-sponsored co-generation energy center that will result in substantial energy savings in the future. Additionally, through a special North Chicago Task Force established by the Co-chairs of the VA/DOD Health Executive Council and the Surgeon General of the Navy, VA and DOD are continuing to explore short and long term options for improved coordination of health care delivery, including review of the possibility of establishing a joint medical facility serving both veterans and Navy personnel.

REGIONAL VA–DOD RESOURCE SHARING

As the VA/DOD Health Executive Council has established a number of work groups to make recommendations to improve cooperation, including a group specifi-

cally reviewing joint facility utilization and resource sharing, VHA and DOD leadership across the country have begun to engage in more vigorous coordination initiatives. For example, DODs Mid-Atlantic Region (Region 2) and VA's Veterans Integrated Service Network (VISN) 6 recently met in November 2001 to discuss potential measures to maximize interagency use of federal resources in the area. The group plans to build on successful collaboration efforts in laboratory and pathology. Laboratory and pathology "Centers of Excellence" have been designated for facilities to purchase laboratory and pathology services at considerable savings. Region 2/ VISN 6 are currently exploring establishing a joint community based outpatient clinic in eastern North Carolina and consolidated surgery services in the Portsmouth/Hampton, Virginia area.

Also, VHA's VISN 20 and DOD's Northwest Region 11 held meetings in the fall and winter of 2001 to discuss additional opportunities for improved coordination. Many areas of promise were identified including: physician staff support in a number of specialties; nursing support and education; VA use of DOD operating rooms, VA clinics' use of DOD military treatment facilities (MTFs) for referral laboratory services, inpatient urology, and emergency hospitalizations; VA's use of DOD's contract for referral laboratory services; and examining 220 region contracts in excess of $24 million to consolidate procurements and make use of existing shared-use contracts.

LOCAL VA–DOD SHARING

Although the senior leadership of VA and DOD are providing leadership support and direction for improved interagency coordination at all levels of interaction, sharing between VA and DOD at the local level is not a new or static concept. As a matter of fact, health care officials almost universally declare that "health care is local," making facility level coordination efforts extremely important to improving health care delivery to our beneficiary populations. The recognition of the value of interagency collaboration between VA and DOD is at least 20 years old and the nature of collaboration over the past two decades has been dynamic, reflecting changes in law, changes in leadership, and changes in the way we deliver health care in the United States.

As you know, Congress passed the "VA and DOD Health Care Resources Sharing and Emergency Operations Act" in 1982, and amended it in 1992. Innovative leadership at the local and regional levels has leveraged this authority to benefit military and veteran beneficiaries.

Currently, there are 165 VA Medical Centers with at least one sharing agreement with a DOD partner. Most MTFs also participate. At the close of FY 2001 there were 604 agreements covering 6,602 services. Most agreements cover diagnostic and ancillary services such as clinical pathology, radiology, audiology, and nuclear medicine. These agreements provide both VA and MTFs with a cost effective mechanism to secure expanded capacity to meet the health care needs of their beneficiary populations and also provide both departments an alternative to procuring services through potentially more costly private sector sources.

It should be noted, however, that the direct sharing relationship between VA and DOD has changed over the years and is currently in decline. The number of agreements has declined from nearly 1,000 to 604 from FY 1998 to FY 2001 while the total number of services covered in all agreements dropped from nearly 10,000 to 6,602 in the same time period. Total VA reimbursable collections from agreements reached a high figure of $32.5 million in FY 1999, declining to $27.9 million in FY 2001. VA purchased from DOD $23.9 million in services in FY 1999. This figure declined to $20.4 million in FY 2001. With the DOD roll-out of the TRICARE managed care support contract program, use of many of these direct sharing agreements between local facilities have been suspended (even though the departments still list these agreements as "active") because local facilities frequently do not formally cancel their interagency direct sharing agreements. We are committed to working together at the national level to increase VA's presence in the TRICARE networks and use of VA when clinically appropriate.

We also have many VA/DOD agreements that involve reserve units from the Army, Army National Guard, Naval Reserve, Air Force Reserve, and Air Force National Guard. Eighteen of VHA's 21 Veterans Integrated Service Networks (VISNs) have agreements to provide physicals to Army Reservists working with the Department of Health and Human Services' Federal Office of Occupational Health.

JOINT VENTURES

Joint ventures are designed to avoid duplication of medical facilities, expand access to services for federal beneficiaries, and to curtail federal health expenditures

through 'economies of scale.' The seven main VA/DOD joint venture sites are listed below:

JOINT VENTURE SITES

Partner	Host	Beds	Clinics
Albuquerque, NM, Kirtland AF, Clinic.	VAMC	Joint admission privileges.	AF has outpatient, dental clinics, Joint staffs provide services
El Paso, TX, Clinic	Beaumont Army	VA purchases	VA has outpatient clinic, VA, Army surgeons share
Las Vegas, NV, VA clinic.	Air Force	VA–52 beds, AF–42 beds.	Surgery and Medicine staffs are integrated
Anchorage, AK, VA clinic.	Air Force	VA–10 bed ICU, AF–25 beds.	Joint staffing of most services
Key West, FL, VA shares space.	Navy (clinic)	VA occupies 10% of space.	Joint staffing of full range of clinical services
Honolulu, HI, VA clinic	Tripler Army	VA purchases	VA provides inpatient psychiatry, Army staffs other services
Fairfield, CA., VA clinic	Travis AF	VA purchases	AF provides most services including outpatient specialty

Recently, this list of joint ventures has been informally expanded to include an eighth site, recognizing the significant collaboration efforts between the VAMC Lawton, OK and Ft. Sill.

The VA/DOD Health Executive Council Joint Facility Utilization and Resource Sharing Work Group has been tasked to make recommendations for improved coordination of services where VAMCs and MTFs are in close proximity as well as in those areas where either a VA or DOD health care facility may be used to provide medical care to the beneficiaries of both departments.

TRICARE AND VA

In 1995, DOD established the TRICARE program to deliver health care services to its beneficiary population through regionally based managed care support contracts. VA provides services to TRICARE beneficiaries as long as veteran beneficiaries are not negatively impacted. VA Medical Centers currently have 134 contracts to provide services. TRICARE earnings, still relatively small, are steadily increasing ($ in millions):

Fiscal year:	
1996	$1.9
1997	$2.8
1998	$3.5
1999	$4.9
2000	$6.5
2001	$9.8

However, as of September 30, 2001, only 90 VA Medical Centers reported reimbursable earnings from TRICARE. The degree of participation varies considerably from one facility to another based on a number of factors.

Prior to implementation of the TRICARE program, it was relatively easy for local VA and DOD officials to develop an interagency agreement to share health care resources. Under TRICARE, however, the nature of interagency sharing has shifted from direct sharing between equal Federal partners to VA primarily functioning in a subcontractor role, making sharing between DOD and VA more complicated. VA administrative costs are higher under TRICARE than with sharing agreements established directly between a DOD facility and a VA medical center. Moreover, given the cost advantage of VA, and the administrative expenses associated with the TRICARE contracts, the government likely pays more for the services provided under TRICARE than would be the case with direct purchase from VA without going through the TRICARE provider networks.

Many VA facilities do not have the capacity to offer primary care to large numbers of TRICARE beneficiaries, even though VA can provide outstanding specialty care and advanced diagnostics in the same area. However, under TRICARE, if a provider does not supply primary care services, referrals are less likely to be made to that provider for specialty care and advanced diagnostics. While not a universal trend, in some locales TRICARE contractors have been less than enthusiastic in welcoming VA participation when they already have well established networks of

providers or, in some instances, there are exclusive contracts or special relationships with other providers. As well, a further disincentive under TRICARE is that DOD beneficiaries incur co-pay and deductible expenses out-of-pocket for care at a VAMC unlike at an MTF where there is no cost-sharing for care.

Finally, VA Medical Centers have had difficulty performing administrative functions eliminating TRICARE billing inefficiencies such as collection of co payments at the point of service, data and coding accuracy, and billing of other is primary" health insurance (after which TRICARE is secondary payer). However, progress is being made. VHA plans to issue a directive outlining proper TRICARE billing procedures. A variety of different formats are being explored using a variety of methods such as training software, videotapes for individual training credit, and satellite broadcasts. In FY 2001, 21 VAMCs were reimbursed at least $100,000, up from 19 in FY 2000.

We are continuing to work with DOD to assure that TRICARE beneficiaries can avail themselves of health care from VA. Over one million veterans are dually eligible for both VA and DOD health services, and we believe there are opportunities to better serve them and to do so cost effectively. Agreement on the appropriate future role of VA in the DOD TRICARE program is important to future collaboration between VA and DOD. This issue is also under discussion with the President's Task Force.

CONCLUSION

VA and DOD are working at all levels to expand and improve our sharing relationships. In addition to those specifically discussed, we continue to cooperate on homeland security, contingency planning, and emergency management. We have made progress in recent years, but I believe we can do more. Dr. Chu and I have committed to ensuring that both our departments work together as effectively as possible.

This concludes my statement. My colleagues and I will be pleased to answer any questions members of the Committees may have.

STATEMENT OF DR. DAVID S.C. CHU, UNDER SECRETARY OF DEFENSE (PERSONNEL AND READINESS)

INTRODUCTION

Mr. Chairman, I am pleased to present to you and the members of the Subcommittee the Department of Defense's strategic vision and objectives for improving the partnership between the Department of Defense (DOD) and the Department of Veterans Affairs (VA).

DOD places enormous value on its relationship with the VA. Since the outset of the sharing program which was established under the 1982 legislation, "Department of Veterans Affairs and Department of Defense Health Resources Sharing and Emergency Operations Act (38 U.S.C 811(f)), DOD has subscribed to the promise for improved service to our personnel and economies of operation that health resources sharing has held. Resource sharing between VA and DOD facilities over the intervening years has resulted in the growth of sharing from a few agreements in the early years to over 600 sharing agreements in place today. However, many of these agreements are not fully utilized or active.

While DODs collaboration with the VA dates back many years and much has been accomplished, it is time to reinvigorate these collaborative efforts to maximize sharing of health resources, to increase efficiency, and to improve care for the beneficiaries of both departments. The focus of our efforts is to move the relationship with the VA from one of sharing to a proactive partnership that meets the missions of both agencies while benefiting the servicemember, veteran and taxpayer.

As I travel around the country meeting with our service men and women, I am also visiting our joint ventures, the VA Medical Centers (VAMCs) that are co-located with our bases, and potential areas of future collaboration with the VA. In December, I visited Tripler Army Medical Center where the DOD/VA cooperation has reached an advanced stage, with Tripler providing over $14 million a year in care to VA patients, with a variety of staff and service sharing agreements in place or planned. In January, I visited San Diego Naval Medicine Center; as you know, in Southern California VA facilities are part of our TRICARE network of providers. In February, I visited the VAMC in Denver, Colorado, where they are discussing a new joint construction model with the University of Colorado. Last week, I visited Travis Air Force Base where a new VA clinic has just been opened next to the Air Force hospital. I also visited our joint venture at Nellis Air Force Base where the Air

Force and VA jointly run an inpatient facility, maximizing their resources to provide the full range of health care services to VA and DOD beneficiaries. Looking toward the future, I just visited the Naval Hospital Great Lakes and the North Chicago VA Medical Center, where DOD and VA are proactively examining options for a joint health care operation in the future. While I believe there is still more work to do, I have seen more activity in the field between DOD and VA than I believe our data systems report.

On February 11th, Dr. Mackay and I held a meeting bringing together our top health care and benefits experts at DOD and VA to discuss how we can together build a more collaborative relationship. We already have a number of initiatives working through our VA/DOD Executive Council, co-chaired by our Assistant Secretary of Health Affairs, Dr. Winkenwerder, and the Acting VA Under Secretary for Health, Dr. Murphy. This council provides the forum for senior health care leaders, including our Surgeons General, to proactively address potential areas for further collaboration, and resolve obstacles to sharing.

We are building on the success of our health care council through the newly established VA/DOD Benefits Council, which is examining ways to expand and improve information sharing, refining the process of records retrieval and identifying procedures to improve the benefits claims process. We will be meeting with the co-chairs of these councils on a quarterly basis to demonstrate our commitment to ensuring they are successful in improving interdepartmental cooperation at all levels.

Concurrent with these ongoing efforts, DOD is actively supporting the President's Task Force to Improve Health Care Delivery to Veterans, announced by President Bush on Memorial Day 2001. DOD has provided office space, administrative support and functional experts to ensure the Task Force accomplishes its mission of improving coordination of health care for veterans and military retirees. I will continue to work closely with my colleague, Dr. Gail Wilensky, to ensure the success of the Task Force in meeting their objectives.

JOINT USE OF DVA/DOD FACILITIES AND SERVICES

A most visible example of Department of Veterans Affairs and Department of Defense partnerships has been the joint venture construction and operation of health care facilities. At present, there are seven joint ventures—eight, if you count a VA clinic sited at Fort Sill, Oklahoma next to the Army Hospital. At Albuquerque, New Mexico, the oldest joint venture between the Air Force and VA is now more than 14 years old. The other joint ventures vary in age and are located across the nation at Key West, Florida, El Paso, Texas, Las Vegas, Nevada, Fairfield, California, Anchorage, Alaska and Honolulu, Hawaii. Each joint venture is unique and complex. But if Albuquerque is any example, they are durable and provide great access and health care to the beneficiaries of both departments. The joint ventures have typically resulted from both agencies coordinating their health care needs and integrating their requirements in well planned out economically justified joint operations. I believe that we should interface our health care planning and jointly assess our future construction needs and, where possible, satisfy those needs through joint venture operations.

In other examples of our partnering, we have taken advantage of changes in medical facility size requirements to provide greater access and cost-effective use of facilities. An example is the VA Medical Center in Nashville, Tennessee, and Blanchfield Army Hospital at Fort Campbell, Kentucky. These two facilities have a barter agreement. Nashville leases space for outpatient services for veterans. Blanchfield provides laboratory and radiology services for veterans. VA provides internal medicine physician services. Pharmaceuticals are exchanged on a per drug basis. Nashville is negotiating with the Army for VA to establish a Community-Based Outpatient Clinic. VA would provide physicians for specialty clinics in such areas as cardiology, pulmonology, internal medicine, oncology and infectious diseases. Fort Campbell is approximately 65 miles from the Nashville VA Medical and 100 miles from the Murfreesboro, Tennessee, VA Medical Center.

Another example is at Louisville, Kentucky, where the VA Medical Center enhances the capabilities of the Ireland Army Hospital at Fort Knox, Kentucky, by providing staffing for Ireland's primary care clinics, fully staffing the TRICARE primary care clinics and supporting numerous other MTF clinics and services including outpatient mental health, well women's clinic, podiatry, urology, internal medicine, audiology, orthopedics, orthotics, radiology, prenatal nurse educator, oncology nurse case manager and various other administrative services. VA maintains a Community-Based Outpatient Clinic at Ireland. Inpatient and outpatient referrals are made to Louisville 40 miles away.

EDUCATION AND TRAINING

In the areas of education and training support, we share 320 VA/DOD agreements, including training for physicians and nurses. These agreements typically involve training opportunities in exchange for staffing assistance. Most agreements are between VAMCs and reserve units. Under a typical agreement, a VAMC provides space for weekend training drills, and, in return, the medical center receives staffing support. For example, the Tucson, Arizona, VA Medical Center trains nurses, technicians and dietitians of the 162nd Medical Squadron, Arizona National Guard, Tucson. In another agreement, the VA provides training for hospital corpsmen for the Naval Reserve and Marine Corps Reserve Center, Tucson. The medical center has similar agreements with six other reserve units in the area.

The communities benefit from the close relationships that develop as a result of these agreements. A large number of VAMCs have agreements involving five or more reserve units. This joint training occurs in areas that truly have contemporary relevance including shock trauma, aeromedical evacuation, disaster preparedness, surgery, psychiatry, and pathology.

MEDICAL RESEARCH

VA/DOD collaboration in medical research is widely known, especially in the area of post-traumatic stress disorder, infectious diseases, traumatic brain injury and spinal cord injury. This past year, research projects were selected based on merit, scientific review and relevance to the health concerns of veterans and military members. Areas of research include an epidemiological study of Amyotrophic Lateral Sclerosis (ALS) among Gulf War veterans and two clinical treatment trials of chronic health problems among veterans of the Gulf War. The VA and DOD recently completed research and development of an evidence-based clinical practice guideline for treatment of post-deployment health concerns. The guideline will be implemented system-wide in early 2002. Two protocols aimed at improving health risk communication of military unique risk factors among veterans have been funded by the Centers for Disease Control and Prevention (CDC) with data collection to begin in 2002.

DOD VISION AND PRIORITIES FOR 2002

Our vision of DOD/VA coordination is a mutually beneficial partnership that optimizes the use of resources and infrastructure to improve access to quality health care and increase the cost effectiveness of each department's operations while respecting the unique missions of the VA and DOD medical departments. Our guiding principles include collaboration, not integration; providing the best value for the taxpayer; establishment of clear policies and guidelines for DOD/VA partnering; and fostering innovative, creative arrangements between DOD and VA. As DOD moves toward a more proactive partnership with the VA, we have established short-term goals to be accomplished during this fiscal year. These include establishing solid business procedures for reimbursement of services, improving access to health care through VA participation in TRICARE, examining opportunities in pharmaceuticals, facilitating health care information exchange between the departments, and establishing a long-range joint strategic planning activity between DOD and VA.

STANDARDIZED REIMBURSEMENT PROCEDURES

During the 1990s, flexibility was given to VA and DOD to establish locally developed rates for medical sharing agreements. This has resulted in the creation of multiple reimbursement rate structures across the country. The variability in payment structure makes the administration of the billing and collection process more difficult. Establishing standardized reimbursement procedures for sharing agreements between medical facilities will eliminate a significant barrier to increased resource sharing between the two departments.

In July 2001, The VA/DOD Executive Council charged the Financial Management Work Group to develop recommendations for reimbursement policies and practices and streamlining financial processes between the departments. The Work Group is currently focusing on the development of a standardized reimbursement rate that would allow VA and DOD to exchange health care services without having to negotiate individual local rates. Currently, the Work Group is analyzing the appropriate discount rate to apply in order to provide the right incentives to both sellers and buyers of services. Planned implementation for a national rate is scheduled for October 1, 2002.

IMPROVING ACCESS THROUGH VA PARTICIPATION IN TRICARE

The VA and the DOD operate the two largest Federal health care systems with a combined number of beneficiaries in both Departments exceeding 12 million. Opportunities exist to improve access to needed health care services by partnering with all VA facilities in the TRICARE provider networks. In 1995, the VA and DOD signed a Memorandum of Understanding (MOU) to allow the TRICARE managed care support contractor to consider Department of Veterans Affairs Health Care Facilities (DVAHCF) for participation in the contractor's network. The VA facility and providers must meet the TRICARE contractor requirements to participate as a TRICARE service provider.

Since the signing of the MOU, efforts have been under way by the Managed Care Support Contractors to enhance their provider networks by signing up the VA facilities. To date approximately 80% of VA facilities have agreements to be network providers; however, the use by the TRICARE contractors is limited. These agreements complement the existing specialty network and primary care availability in the TRICARE Prime service areas throughout the country.

Our Managed Care Support Contractors have targeted VA facilities throughout the country to enter the TRICARE network. In Region 6, the managed care support contractor has had discussions with the Houston VA Medical Center to re-enter the TRICARE network. In the Central Region, they have moved to the next phase of their partnership strategy by creating a Central Region Federal Health Care Alliance. The critical focus is on fostering collaboration between the DOD and the VA. The Central Region Federal Health Care Alliance is a collaboration among the TRICARE Central Lead Agent Office, the military treatment facilities, TriWest Healthcare Alliance's commercial network, and the VA to provide a coordinated approach to providing quality health care in the most effective and efficient manner. The initial project is targeting the states of North Dakota, South Dakota, and Minnesota. Humana is also entering discussions with the North Chicago VA Medical Center

The enhanced effort to integrate the VA into the Managed Care Support Contractor's networks will improve access to specialty and primary care services that are not currently available in certain sections of the United States. A partnership with the VA for 100% of facility participation in the TRICARE networks will maximize the capabilities of both federal agencies and fully utilize the federal health care services.

As DOD moves toward the next generation of TRICARE contracts, we have active VA participation in the formulation of policies and procedures governing our partnership.

PHARMACEUTICALS

We continue to experience remarkable success in our joint pharmaceutical-related efforts. Progress is being made to enable DOD to use the VA Consolidated Mail Order Pharmacy later this year. DOD is also discussing VA participation in the Pharmacy Data Transaction Service (PDTS), which allows DOD to build a patient medication profile for all beneficiaries regardless of the point of service. Since its full implementation, PDTS has identified over 20,000 life threatening interactions resulting from beneficiaries using more than one pharmacy for prescription service. We feel that VA could truly benefit from this system. Also, our joint DOD/VA contracting for pharmaceuticals is really paying off. VA and DOD have joint national pharmaceutical contracts which are developed through the collaborative efforts of the VA National Acquisition Center (NAC), the VA Pharmacy Benefits Management (PBM) Strategic Health Group, the Defense Supply Center Philadelphia (DSCP) and the DOD Pharmacoecononiic Center (PEC). To date, the VA and DOD have jointly awarded 57 joint pharmaceutical contracts with a projected annual cost avoidance in excess of $100 million.

FACILITATING HEALTH CARE INFORMATION EXCHANGE

DOD strongly supports the need for appropriate sharing of electronic health information across federal agencies. This is particularly true with the VA to ensure they have the information necessary to make determination of benefit decisions and to ensure the continuity of care of eligible veterans. The Federal Health Information Exchange, formerly known as the Government Computer-based Patient Record (GCPR), is a collaborative effort among DOD, VA and the Indian Health Service. The Near Term solution, which is now being tested, will enable DOD to send laboratory results, radiology results, outpatient pharmacy, and patient demographic information on separated Service members to the VA. Before FY 2005, we expect that

the patient record information will flow not only to VA, but also from VA to DOD. This disclosure of protected health information to the VA will be compliant with the Privacy Act and the Health and Human Services regulations on Standards for Privacy of Individually Identifiable Health Information under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. The INVIT Work Group under the VA/DOD Executive Council is currently coordinating a Memorandum of Agreement that will institutionalize this data exchange between the two Departments. An assessment of requirements for additional data is underway.

We are also working with VA to determine and enhance the degree of compatibility in information assurance policies and guidance and data architecture standards. Our work has already revealed that we have a number of standards in common. In addition, we are developing and testing an interface for electronic transfer of reference laboratory data between our respective health information systems and commercial laboratories to replace current manual methods.

We have joined in medical automation research in the Defense Information Research Center. We have linked DOD's Composite Health Care System and VA's Veterans Information Systems and Technology Architecture (VISTA), successfully tested clinical laboratory data exchange, and accelerated evaluation of off-the-shelf software in the automation of patient records. Sharing information about our patients, particularly when our two agencies may treat the same patient, is vital to ensure continuity of care. DOD and VA continue to work on the sharing of information contained in each agency's health care information system. For example, we are actively exploring opportunities for sharing our enrollment database (DEERS) with the VA through our VA/DOD Benefits Council.

ESTABLISHING A LONG-RANGE DOD/VA STRATEGIC PLAN

Since 1982, the two Departments have worked hard to generate increases in sharing and associated cost savings. The partnership has weathered several rounds of military hospital closures, and a dynamic and fluid health care environment. We have been successful by looking toward the future, not the past. In that regard, DOD believes there could be more opportunity for partnering through a strategic planning process that would allow the two Departments to identify for themselves the opportunities for greater coordination and collaboration. Through the VA/DOD Executive Council, DOD will propose the establishment of a Joint Strategic Planning Committee to report directly to the Co-Chairs of the VA/DOD Executive Council. This committee would be charged with developing a long-range strategic planning document for 2003–2009. The strategic planning effort will encompass health care resources, capital assets, contingency roles and IM/IT opportunities. We also look forward to participating in the VA's Capital Asset Realignment for Enhanced Services (CARES) study in an effort to jointly examine opportunities for future health care collaboration.

FUTURE CHALLENGES AND OPPORTUNITIES

While the advantages of our sharing agreements, joint facility utilization and clinical collaboration are apparent, the evolving environment of federal health care and recent changes in policy and benefits call for continuing reassessment of opportunities that are mutually beneficial for our systems. As we work toward a closer partnership with VA, we must continue to address the ongoing challenges of different, but not mutually exclusive, missions, populations and cultures. As an example, the VA population is a far older group, often with chronic conditions. In contrast, more than half of DOD's eight million beneficiaries are age 44 or younger, and 50% of our beneficiaries are female compared to 5% of the VA population. The DOD's military treatment facilities are constantly involved in wartime readiness and training activities. As we continue to respond to the ever-changing health care environment, the DOD leadership recognizes that it must develop creative approaches to health care delivery while retaining the flexibility to respond to the demands of our dual mission of operational and everyday medicine.

CONCLUSION

Mr. Chairman, my VA colleague, Dr. Mackay, and I, share a common vision of quality health care for our men and women serving our country, their families, and those that have served us so well in the past. DOD's concern for the well-being of our servicemembers extends beyond just their time on active duty. Cooperative efforts with the VA will provide the best possible service through new initiatives and increased efficiency to the benefit of the servicemembers, veterans and taxpayers.

STATEMENT OF NANCY DORN, DEPUTY DIRECTOR, OFFICE OF MANAGEMENT AND BUDGET

Chairman McHugh and Chairman Moran and Members of the Subcommittees: Thank you for the opportunity to address an issue that is among the highest priorities of this Administration. One of President Bush's campaign promises was to invest in health care, and a component of that promise was to better coordinate the programs and benefits of the Department of Defense (DOD) and the Department of Veterans Affairs (VA). This commitment was first described weeks after the inauguration in the President's Blueprint for New Beginnings FY 2002 budget document. A few months later, President Bush issued an Executive Order to create The Presidential Task Force to Improve Health Care Delivery for Our Nation's Veterans to ensure that all options of coordination would be explored. At the same time, we released the FY 2002 President's Management Agenda, where coordination of DOD and VA programs and systems was one of 14 government-wide initiatives. Finally, the recently released FY 2003 Budget incorporated this priority. These four actions in the first year of this Administration clearly show that this President is committed to seeing progress in this area. Unlike any other Administration, we want to see results on a grand scale—not just on an ad hoc basis—to better serve our Nation's veterans. I would emphasize that this is not a budget cutting drill. It is an effort to ensure better access and quality of care, and a seamless transition from active service to veteran status.

You will hear detailed descriptions of the efforts of DOD, VA, and the Task Force from the other distinguished panel members. I will be summarizing some of the key items from the Executive Office of the President's perspective. However, first, let me describe the changes that we made within The Office of Management and Budget to ensure maximum and effective attention to this Presidential priority. In February of last year, we reorganized so that all DOD and VA policy issues are addressed by the Associate Director for National Security Programs, and DOD and VA health systems are addressed in the same Branch. This created an environment that fosters greater partnership and coordination of decisions within the Administration. We have already seen the benefit of this new structure as we address the myriad of policy, management, and budget issues. For example, justifications for proposed medical care construction projects must now include a joint effort assessment. Information technology funding is monitored to ensure that we do not develop independent capabilities when both medical care systems have a mutual need for similar systems.

The Director of OMB is personally committed to this effort, as is the Domestic Policy Council. We have supported the Task Force efforts continually since its inception and DOD and VA coordination is a team effort in this Administration. We are particularly proud of the focus of the leadership in both Departments on the issue. While sharing and coordination has taken place for years between the agencies on an ad hoc basis—this is the first time that the leadership of both Departments have ensured that this is a high priority, and communicated and monitored the priority within their organizations. Together they are tackling global issues that can set a framework for the future.

How do we see coordination efforts helping the military members and veterans directly? Two overarching areas of coordination will play a big role in the quality and access of service—information technology and facility sharing. Sharing information and technology can make a world of difference. It can speed up service, ensure safer healthcare, and inform veterans of earned entitlements. In addition, it can transport information from one Department to another—continually providing fuel for innovative managers to improve service. All veterans, by definition, were once members of the Armed Services. While on active duty their information was tracked by a system that covered everything from security clearances, to health care entitlements, to commissary privileges. There is no reason that when military members leave service that they must provide information on paper to VA that is already on computers at DOD. Likewise, when these same veterans and their families apply for multiple types of VA benefits, they should not have to provide identical information each time. The President's Management Agenda includes an initiative that would improve the VA enrollment systems. Such a system should make transition from active duty to veteran status seamless and include the eligibility and enrollment status for each of the numerous DOD and VA benefits. For over 20 years, the DOD has operated a centralized automated system to enroll and track individuals having entitlements to DOD benefits and services called the Defense Enrollment/Eligibility Reporting System (DEERS). DEERS is a large database that accurately records the benefits eligibility information for over 20 million beneficiaries in multiple government agencies and could be expanded to include VA. DEERS is uniquely

positioned to bridge the gap between the two Departments. It already supports a modest level of real-time exchange of information on veterans, setting the stage for even closer cooperation. The Departments are exploring their mutual options in this area. While there may be some up-front costs of using DEERS for VA, there should be long terms savings. We have not calculated these costs or savings yet.

One other area of coordination of information technology that we are addressing is in the medical care area. Both DOD and VA create independent patient medical records when a beneficiary uses its health care systems -just as files are created for you when you visit your doctor. Each Department has aggressively moved towards computerizing these records to allow all medical providers throughout its own system to access and rapidly update individual patient records. Since all veterans start out in the DOD system and hundreds of thousands of them use both systems annually, it is imperative that this effort be coordinated. This challenge can be achieved and would improve overall health care. Currently, if a patient sees a DOD doctor on Wednesday, it is very difficult to ensure that treatment and medication are consistent with those the patient obtained from a VA doctor on Monday. Managing care is critical to well-being. One of the Administration's E-Government initiatives is Health Care Informatics, and development of a patient record system falls under its scope. Hence, developmental efforts in both Departments will focus on interoperable information technology solutions. This is a major effort, which will likely require a sustained, multi-year effort to implement completely.

Active duty personnel, dependents, and veterans all benefit by DOD and VA sharing facilities when appropriate. The two Departments share less than ten facilities today. In many communities, DOD and VA hospitals are close to each other and offer similar services (e.g. primary care, surgery, or eye care). However, traditionally neither has considered the other as an option in determining construction or health delivery needs. In light of the new emphasis on sharing, DOD and VA are working together to solve mutual problems in a number of areas where both Departments have facilities located close to one another.

We are working with DOD and VA on a multitude of other coordination issues including patient transportation and medical training. On the transportation side: if a veteran patient needs to be moved long distances from one VA hospital to another, he is typically transported via commercial airline. This is expensive. DOD routinely transports military patients in planes with unused space. DOD and VA are assessing how, where, and when to put VA patients on DOD planes. Where appropriate, this will ensure any needed medical attention in the air for the patient, provide DOD with more patients on these transports to enhance readiness skills, and lower the cost to both Departments. On the medical training side: DOD has a relatively young and healthy patient population, but to maintain physician readiness skills sends some physicians to private sector facilities to work with more complex patients at a cost to DOD. VA has an older patient population with a broader range of health complications that are more severe and complex than patients seen in DOD. VA's medical system is recognized as a world-class training organization and has provided some portion of medical training to most practicing physicians in the United States. GAO reported that DOD physician's who worked with VA patients in DOD/VA sharing initiatives reported increased proficiency due to the broader range of patients. DOD and VA have initiated discussions to create a pilot program for DOD to place some medical providers in VA facilities for skills enhancement training.

Finally, let me address the President's proposal that would ensure that military retirees choose either DOD or VA as their health care provider through annual open enrollment seasons. This legislative proposal was included in both the FY 2002 and FY 2003 President's Budgets, and would ensure higher-quality care and more efficient use of resources. We believe it is imperative to coordinate the care provided to military retirees by these two agencies. Under our proposal, retirees using both systems for health care in the same year would do so under managing physicians' oversight and direction. They would benefit from having one health care system arrange for all of their health care and prescriptions. As in the current situation, all families of retirees would remain with DOD, since VA treats only retirees themselves. The key to this proposal is informed choice. Retirees would evaluate, on an annual basis, which agency provides the most appropriate setting for their health care needs, much as other federal employees do each year in the Federal Employees Health Benefits Program. However, while a retiree might choose DOD as his or her primary health care program, he or she will not necessarily be prevented from utilizing VA's services. Currently, 137 VA Medical Centers contract with DOD's health care program, TRICARE, to provide a variety of health care services. We intend that this sharing relationship continue and expand, such that retirees who choose DOD

as their primary health care system may be referred to VA by DOD for certain services, including those VA specialty services used by disabled military retirees.

In closing, I hope I conveyed to you in this short summary how important DOD/VA coordination is to the President and some of the areas that the Administration is pursuing to ensure top quality services to military members and their families and veterans. Our efforts are a good first start, but we will need your help and support to make it work.

This concludes my prepared statement. I would be pleased to respond to any questions that you might have.

STATEMENT BY GAIL R. WILENSKY, CO-CHAIR, PRESIDENT'S TASK FORCE TO IMPROVE HEALTH CARE DELIVERY FOR OUR NATION'S VETERANS

Mr. Chairman, Members of the Subcommittees, thank you for inviting me to appear before you today to discuss health care sharing between the Department of Defense and the Department of Veterans Affairs. For those of you I haven't met, my name is Gail Wilensky. In addition to serving as the Co-Chair of the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans, I am a John M. Olin Senior Fellow at Project HOPE, an international health education foundation, former administrator of what used to be known as HCFA, the Health Care Financing Administration, and former chair of two congressional advisory commissions on Medicare.

President Bush created the Task Force last May 28 to honor a campaign commitment he made to improve health care for veterans who have served this Nation. In the Executive Order, President Bush charged the Task Force with identifying the following: 1) ways to improve benefits and services to veterans and military retirees; 2) barriers and challenges to making those improvements; and 3) opportunities for more efficient resource sharing by the VA and DOD, the two largest agencies in the Federal Government, with two distinct cultures and missions.

The Task Force had its own challenges to overcome. The tragic events of September 11 forced postponement of the inaugural meeting an entire month. The October 26 unexpected death of your former colleague and my Co-Chair, Congressman Jerry Solomon was a terrible loss. We all miss his wise counsel, but we are determined to honor his legacy by carrying on with our duty and crafting recommendations the President and Congress will judge to be as wise as they are practical.

I can tell you that the cooperation and support I've gotten, from the gentlemen with me today at the witness table have been excellent, and I am grateful.

As mandated in the Executive Order, we will give you the first round of those recommendations in July. We expect to issue our final report, with more specific recommendations, in March of 2003.

With each meeting we've focused more sharply on both the barriers and opportunities for greater cooperation and sharing between VA and DOD. We've done that by organizing the Task Force into seven "workgroups" to break down an enormous wealth of data into digestible parts for analysis and action. Those workgroups are: Benefits Services, Leadership and Productivity, Information Management/Information Technology, Facilities, Pharmaceuticals, Acquisition and Procurement, and finally, Resources and Budgeting.

The Benefits Services Workgroup will study eligibility, access, the impact of TRICARE for Life, reducing waiting times, and the different benefit structures of the two departments. The Leadership and Productivity Workgroup will concern itself primarily with ways to establish accountability and responsibility for greater coordination and sharing between the VA and DOD. The IM/IT Workgroup will examine the review and approval processes for major IT systems, and look for ways to build bridges between two very different technical architectures in the VA and DOD IT systems.

As their title suggests, the Facilities Workgroup will recommend ways to improve the maintenance of infrastructure and improve the capacity of the VA and DOD to respond to future changes in health care. Their scope will include the approval process for major construction projects and the potential for greater collaboration in future projects. The Pharmaceutical Workgroup will take a close look at the 57 joint VA/DOD national contracts, the 35 pending and 30 proposed joint contracts. The assumption is that jointly contracting for pharmaceuticals will lead to better prices than if done by each agency alone, The workgroup will also study mail order pharmacy systems, possible joint formularies, and how an additional workload of DOD beneficiaries would affect the VA.

The Acquisition and Procurement Workgroup will concern itself not so much with what should be jointly purchased, but what processes should be followed to allow

joint buying when both agencies think it is appropriate. They will take a very close look at the next generation of TRICARE contracts. The Resources and Budgeting Workgroup will focus on how to achieve the most efficient use of health care resources. They will examine five types of sharing: direct, VA as a network provider under TRICARE, joint ventures, joint purchasing, and collaboration in other areas.

We have staffed these workgroups with consultants who have both VA and DOD expertise as well as substantial subject matter expertise. The work of the consultants is being supplemented by detailees from the VA and DOD selected because of their expertise in each of the workgroup areas. The job of the combined staff is to analyze previous reports on VA/DOD sharing and to determine the status of recommendations in those reports. In addition to our regular Task Force hearings, we've held and will continue to hold, less formal meetings with veterans and military retiree organizations, the Surgeons General of the military branches, congressional staffers, VA and DOD staffers, and a variety of other experts in health care and related fields.

Task Force Members and staff have also taken three trips to sites where VA and DOD already have joint ventures and sharing arrangements of varying kinds, and more site visits are planned for the future. These visits are just as important as studying the available literature, because they allow us to examine what works and what doesn't, and to get first-hand accounts from the very people asked to carry out sharing activities.

We've found that these joint ventures are great targets of opportunity, especially when it comes to expansion and construction of facilities. When VA and military facilities are located close to each other, it often happens that what one lacks the other has to share. It's simply a matter of creating as many "win-win" situations as the imagination can conceive.

One thing needs to be emphasized. The recommendations in our final report will go far beyond the mechanics of sharing and joint ventures. Task Force staff and members are focusing on ways to increase collaboration and coordination between the two departments as well as ways to improve business processes that enhance the services of both departments in a way that is transparent to the health care user in transition from one system to the other. VA and DOD need to continue thinking in broader terms than sharing and joint ventures, important as those two activities may be.

Success in these activities and in everything else the Task Force is considering is contingent on leadership. When both the VAMC director and commander of the military hospital are determined to make such arrangements succeed, you can be sure they will, whether or not they have the support and resources they need from further up the chain of command. The Task Force wants to issue recommendations that, if carried out, will transcend personalities and become so institutionalized that leadership turnovers have no negative impact on sharing arrangements.

I would like the Chairmen and all Members of the two subcommittees to know that our concern goes far beyond the two departments to the very object of the President's Executive Order and our Task Force Charter. Our concern is for the veteran and military retiree who have served their Nation, often at considerable sacrifice. These men and women need to be able to access health care from the VA and DOD through a process that should be seamless and transparent.

The mission of the Task Force is not to lay blame, nor is it to remake the health care systems of the VA and DOD. But when we are finished, we intend to present to the President and the American people recommendations that, if carried out, will improve the delivery of health care to our nation's veterans. I will be happy to respond to your questions.

STATEMENT OF THE MILITARY COALITION, PRESENTED BY SENIOR CHIEF ROBERT WASHINGTON, USN, (RET), FLEET RESERVE ASSOCIATION

Robert Washington, Sr. is Director of Member Services for the Fleet Reserve Association (FRA). He joined the Association in February 1988 and has been a continuous member ever since. He is a retired Senior Chief Yeoman. Before joining the FRA National Headquarters staff in 1998, he was the Navy's Senior Enlisted Advisor for the Defense Information Systems Agency in Arlington, Virginia.

He enlisted in the United States Navy in December 1971, and served continuously until his transfer to the Fleet Reserve. During his career, he served aboard the USS *Strong* (DD–758), USS *Simon Lake* (AS–33), HS–17 onboard USS *Coral Sea* (CV–43), USS *Mount Whitney* (LCC–20), and was embarked in COMCARGRU FOUR staff, Norfolk, Virginia. He also served at the following shore duty command: Staff MINERON Twelve, Charleston, South Carolina; PSD, NTC, Orlando, Florida; PSD

Crystal City, Arlington, Virginia; Bureau of Naval Personnel, Washington, DC; DISA, Arlington, Virginia. He is also a graduate of the Navy Senior Enlisted Academy, Newport, Rhode Island.

As Director of Member Services, he works hand-in-hand with The Military Coalition (TMC) and Congress on healthcare issues involving active duty members, reservists, and military retirees and their family members. The Coalition represents over five million active duty, reserve, and retired military personnel, and veterans. Washington also serves as cochairman of TMC's Healthcare Committee, as a representative to the Navy and Marine Corps Council, the Department of Defense Healthcare Initiatives Review Panel, and the Uniformed Beneficiary Pharmacy Advisory Panel.

He is presently serving as president of Navy Department Branch 181, Fleet Reserve Association, Arlington, Virginia, as Chairman Central Liaison Committee for the Northern Capitol Region, and Chairman of the Association's Bylaws and Rules Committee, East Coast Region.

He was born in Charleston, South Carolina, and was raised and educated in that city. He and his wife, Debra, currently reside in Oxon Hill, Maryland, they have two sons and one daughter.

MISTER CHAIRMAN AND DISTINGUISHED MEMBERS OF THE SUBCOMMITTEE. On behalf of The Military Coalition, a consortium of nationally prominent uniformed services and veterans organizations, we are grateful to the Subcommittee for this opportunity to express our views concerning issues affecting the uniformed services community. This testimony provides the collective views of the following military and veterans organizations, which represent approximately 5.5 million current and former members of the seven uniformed services, plus their families and survivors: Air Force Association; Air Force Sergeants Association; Air Force Women Officers Associated; Army Aviation Association of America; Association of Military Surgeons of the United States; Association of the United States Army; Chief Warrant Officer and Warrant Officer Association, U.S. Coast Guard; Commissioned Officers Association of the U.S. Public Health Service, Inc.; Enlisted Association of the National Guard of the United States; Fleet Reserve Association; Gold Star Wives of America, Inc.; Jewish War Veterans of the United States of America; Marine Corps League; Marine Corps Reserve Officers Association; Military Chaplains Association of the United States of America; Military Order of the Purple Heart; National Guard Association of the United States; National Military Family Association; National Order of Battlefield Commissions; Naval Enlisted Reserve Association; Naval Reserve Association; Navy League of the United States; Non Commissioned Officers Association; Reserve Officers Association; The Retired Enlisted Association; The Retired Officers Association; The Society of Medical Consultants to the Armed Forces; United Armed Forces Association; United States Army Warrant Officers Association; United States Coast Guard Chief Petty Officers Association; Veterans of Foreign Wars; Veterans' Widows International Network.

The Military Coalition, Inc., does not receive any grants or contracts from the Federal Government.

EXECUTIVE SUMMARY RECOMMENDATIONS OF THE MILITARY COALITION

The Military Coalition's position on VA/DOD health care sharing is clear. The Coalition supports any efforts to improve coordination between the two departments, but only if those efforts would enhance or maintain access to health care, quality, safety, and services offered to beneficiaries of each of the departments. It is imperative that the final outcome reflects either a continuation of benefits at the same level or enhanced benefits for all beneficiary populations. No decision should be made, regardless of how "business-wise" it may seem, unless it is clear that all beneficiary groups will not be negatively impacted. We look to greater collaboration, not substitution or integration as the solution.

NEAR-TERM OPPORTUNITIES FOR DOD–VA SHARING

Strategic Planning. The Coalition recommends that the government issue a strategic planning document similar to the "National Security Strategy of the United States" that lays out national goals and objectives for DOD–VA collaboration and the ways and means to achieve its stated aims.

VA's Potential as a Tricare Provider

The Coalition recommends that DOD and VA jointly evaluate the current barriers to TRICARE that inhibit the use of the VA as a TRICARE network provider and recommends increased coordination between the VA and the TRICARE Management Activity.

Force Health Protection and Military Medical Surveillance System

The Coalition recommends greater collaboration between the DOD and VA medical systems in military medical surveillance and force health protection since the outcome of such work is beneficial both to national security (force health protection) and veterans' health care and disability claims.

Information Management/Technology and a Common Medical Record

The Coalition strongly recommends development and deployment of a common DOD–VA medical record as quickly as possible, along with the capability to exchange data seamlessly between the two systems using appropriate privacy protections.

Pharmaceuticals

The Coalition recommends review of the pharmaceutical practices of both departments and their mail order pharmacies and urges improved cooperation between the two agencies in this area.

Market-Driven Strategic VA/DOD Collaboration

The Coalition urges the Subcommittees to examine the potential of an ongoing collaboration between Tri West Health Alliance, Veterans' Integrated Service Network (VISN) 23, and Military Treatment Facilities in the TRICARE Central Region for its potential as a model of strategic health care planning on a market-specific basis.

MID-TERM OPPORTUNITIES FOR DOD–VA SHARING

Procurement of Medical/Surgical Supplies and Equipment

The Coalition recommends development of a strategic plan for joint procurement of high cost equipment and supplies, consistent with each agency's mission requirements.

VA Medicare Subvention

The Coalition continues to support testing the feasibility of using Medicare funds in VA facilities for the non-service connected care of Medicare-eligible veterans.

LONG TERM OPPORTUNITIES FOR DOD–VA COLLABORATION

The Future of Co-Located DOD–VA Facilities

The Coalition recommends incorporating an independent strategic assessment of current co-located facilities into CARES and BRAC planning.

H.R. 2667, the Dept. of Defense–Dept. of Veterans' Affairs Health Resources Access Improvement Act of 2001

The Coalition recommends amending H.R. 2667 to specify coordination of care standards for beneficiary groups and guidance to protect earned health care benefits for all stakeholders.

OTHER CONCERNS

Forced Choice

The Coalition strongly recommends the Subcommittees uphold the principle that military retired veterans have earned and deserve access to both VA and DOD care systems and they must not be forced to forego either benefit. Budget-driven proposals should be resolved by the DOD and VA and not visited on the backs of those who earned those benefits through service to their country.

Demographic Tracking of Dual-Eligibles

The Coalition recommends development of better data on military retiree usage of VA care in order to obtain a more accurate picture of demand and cost on that system and improved reimbursement planning between DOD and VA.

CONCLUSION

DOD and the VA have reported through the Executive Council on ways they are collaborating in contracting, administrative and maintenance services, and purchasing. The Coalition is hopeful that these arrangements, if properly administered and

evaluated, could provide models for future collaboration. We believe the two systems can and should work closer together to develop health care quality measures, graduate medical education, and centers of excellence for certain specialty care. The Coalition requests, however, that the Subcommittees encourage collaborative ventures as part of an overall strategic initiative with a primary focus on the needs of each system's beneficiaries.

VA/DOD HEALTH CARE COORDINATION

The Military Coalition's position on VA/DOD health care sharing is clear. The Coalition supports any efforts to improve coordination between the two departments, but only if those efforts would enhance or maintain access to health care, quality, safety, and services offered to beneficiaries of each of the departments. It is imperative that the final outcome reflects either a continuation of benefits at the same level or enhanced benefits for all beneficiary populations. No decision should be made, regardless of how "business-wise" it may seem, unless it is clear that all beneficiary groups will not be negatively impacted. We look to greater collaboration, not substitution or integration as the solution.

NEAR-TERM OPPORTUNITIES FOR DOD–VA SHARING

Strategic Planning

The Coalition supports a strategic analysis of collaboration from the standpoint of how the headquarters levels of both the Department of Defense and the Department of Veterans' Affairs can empower local leaders to work together, holding them accountable for delivering quality health care for both DOD and VA beneficiaries. By thinking strategically while always focusing on desired beneficiary outcomes such as health status and patient satisfaction, the departments can significantly increase collaborative efforts to the advantage of not only the beneficiaries but also for the two systems, as well as the American taxpayers.

In practical terms, a strategic approach to collaboration means defining "joint" requirements that are derived from each agency's unique missions. For example, DOD and VA's missions intersect in the areas of medical research, graduate medical education, mass casualty management, military medical surveillance, and now homeland defense collaboration. Yet, there is no national level policy document (such as "The National Security Strategy of the United States") that adequately spells out how these common mission areas are to be translated into specific requirements along with the capabilities and resources to carry them out in the nation's best interest. Many studies have "come and gone" on the need for improving the planning process between DOD and the VA, but until collaboration is directed at the *highest levels of government,* all of the historic and cultural reasons for not working together will prevail.

The Coalition recommends that the government issue a strategic planning document similar to the "National Security Strategy of the United States" that lays out national goals and objectives for DOD–VA collaboration and the ways and means to achieve its stated aims.

The Coalition maintains that there are significant near-term opportunities that would allow for increased collaboration between the two departments and improve beneficiaries' health care. These include:

1. VA as a TRICARE network provider
2. Force Health Protection and Military Medical Surveillance System
3. Information Management/Technology and a Common Medical Record
4. Pharmaceuticals
5. Market driven strategic VA/DOD collaboration

VA's Potential as a Tricare Provider

The VA's role as a TRICARE network provider is a potential source for increased access to quality health care for all DOD beneficiaries. If VA's capacity allows, and its core mission is not compromised, then the VA should play a vital role in offering primary and specialized care to TRICARE beneficiaries as a network provider.

In a June 1995 Memorandum of Understanding, TRICARE contractors were authorized to include VA medical centers (VAMCs) in provider networks and, therefore, TRICARE contractors were encouraged to use VA facilities. Due to persistent billing and reimbursement problems, VA's potential as a network provider has not been fully realized. Despite 80% of VAMCs currently being considered TRICARE network providers, three-quarters of the activity occurs in only 26 facilities and the total level-of-effort was miniscule according to the GAO (May 2000).

Current TRICARE contracts will begin to expire over the next few years, and the Coalition is pleased that the VA is represented in the new contract development.

TRICARE Management Activity (TMA) has acknowledged the importance of considering the VA in the next generation of contracts. In light of the growth of VA's Community Based Outpatient Clinics (CBOCs), the VA could be a service delivery alternative for TRICARE beneficiaries where capacity exists.

The Coalition supports greater utilization of VA networks in partnership with TRICARE. Although many VA providers are also TRICARE network providers, actual usage has been marginal. Some of the reasons why this partnership has not been fully realized include:

- VA providers are not qualified in specialties most in demand by DOD beneficiaries, i.e., pediatrics and obstetrics and gynecology.
- VA providers often cannot meet TRICARE Prime access standards.
- Business practices in the areas of claims processing, IM/AT systems' incompatibility, conflicts over pricing of services, various administrative limitations and a lack of aligned incentives impede use of VA providers by TRICARE Managed Care Support Contractors.

Expanding the use of VA providers as TRICARE-authorized providers to care for all TRICARE beneficiaries may improve active duty and retirees' access to care in areas where TRICARE Prime is not available.

The Coalition recommends that DOD and VA jointly evaluate the current barriers to TRICARE that inhibit the use of the VA as a TRICARE network provider and recommends increased coordination between the VA and the TRICARE Management Activity.

Force Health Protection and Military Medical Surveillance System

DOD and VA have been collaborating more in recent years on research into operational health-related issues. For example, there are a number of ongoing studies on the causes and treatment of symptoms known collectively as Gulf War illness. This work is valuable to DOD's readiness mission since a critical aspect of medical readiness is to develop "force health protection" strategies that preserve the fighting force and effectively use the tight medical capabilities to support deployed troops. VA's stake in this work is to improve health care delivery for service connected veterans who have been deployed to various operational environments during their service and to facilitate the adjudication of claims for service connected disabilities.

In a recent report (October 16, 2001), the GAO reported that a "medical surveillance system involves the ongoing collection and analysis of uniform information on deployments, environmental health threats, disease monitoring, medical assessments, and medical encounters." The report states that some progress has been made in developing such a system but points out that there remain significant gaps. The report notes that the Gulf War "exposed many deficiencies in the ability to collect, maintain, and transfer accurate data describing the movement of troops, potential exposures to health risks, and medical incidents in theatre." Without reliable deployment and health care information, it was "difficult to ensure that veterans' service-related benefits claims were adjudicated appropriately."

The Coalition recommends greater collaboration between the DOD and VA medical systems in military medical surveillance and force health protection since the outcome of such work is beneficial both to national security (force health protection) and veterans' health care and disability claims.

Information Management/Technology and a Common Medical Record

The FY 2002 National Defense Authorization Act includes a provision (Section 734) that encourages an ongoing pilot program in which the VA conducts separation physicals for the DOD. A software program developed to support the pilot project creates data needed by DOD for the separating service member and concurrently provides the VA with the information needed to make a disability determination. The project eliminates the need for a second physical exam performed by the VA after separation and standardizes a "one exam" process.

Earlier efforts have not been as encouraging. In 1997, the administration directed development of a "comprehensive, life-long medical record for each service member." In January 1998, the VA, DOD, and IHS initiated the Government Computer-Based Patient Record (GCPR) project. Later that year, the two agencies were directed to develop a "computer-based patient record system that will accurately and efficiently exchange information." Initial plans for the project called for its deployment by October 1, 2000, but intermediate target dates were not met. The project now has no defined implementation date. The GAO reported the following problems with the GCPR project in its evaluation:

1. GCPR's cost estimate jumped from $270 million in September 1999 to $360 million in August 2000. Even the 2000 estimate was believed to be understated.

2. The project encountered setbacks due to inadequate accountability and poor planning.

3. At the time, only VA had the capability of sharing certain information across its own regions; DOD's TRICARE regions were unable to share beneficiary health information between them.

4. In the interim effort, requested information took as long as 48 hours to receive.

5. It will not be possible to organize or manipulate the transmitted information. Terms and their contexts are not standardized across VA and DOD, thus making the information meaningless when transmitted.

Notwithstanding these challenges, development of a common DOD–VA medical record has the potential to improve the efficiency and effectiveness of both the VA health care and claims systems, lower DOD and VA medical expenditures, facilitate data exchange for research and other purposes, and help service members and veterans get better health care and prompt, accurate disability decisions.

The Coalition strongly recommends development and deployment of a common DOD–VA medical record as quickly as possible, along with the capability to exchange data seamlessly between the two systems using appropriate privacy protections.

Pharmaceuticals

There are two ways in which the VA and DOD can improve coordination of their pharmacy programs. The first is to increase its joint procurement contracts for common pharmaceuticals, and the second is to provide a link between, or even combine, the departments' mail order pharmacy programs. Both departments currently have a mail order pharmacy program, but neither program is able to communicate with the other. The Coalition believes that both the VA and DOD can save millions of dollars by sharing these pharmacy distribution programs.

The VA currently has a well-established Consolidated Mail Outpatient Pharmacy (CMOP) program, which is considered to be highly efficient and cost-effective. Beginning April 2001, DOD implemented its Senior Pharmacy program, which allowed retirees over 65 to become eligible for use of its National Mail Order Pharmacy (NMOP) and TRICARE network pharmacies. With this program, all DOD beneficiaries now have access to the NMOP and network providers. However, VA beneficiaries are not eligible to use the NMOP, and DOD beneficiaries are not eligible to use the CMOPs.

DOD has conducted an assessment of the costs and time required to develop a computer interface between DOD's military pharmacies and VA's Consolidated Mail Order Pharmacy (CMOP) centers. According to the GAO, DOD has determined that it is feasible to develop the necessary computer interface between military pharmacies and CMOP centers, but it has not developed an implementation plan. DOD is in the process of planning to seek funding for the project. Enhancing the interoperability of the pharmacy programs will both improve the delivery of pharmacy benefits and yield a cost savings for both departments.

Aggressive efforts are being made to jointly procure pharmaceuticals; however, both DOD and VA have conveyed to the GAO the following problems with jointly procuring pharmaceuticals:

1. Culture differences make it difficult to come to an agreement.

2. Beneficiary populations are different for both systems; therefore their pharmaceutical needs vary too much to combine the program.

3. The scope of each of their formularies varies so much to the degree that joint drug procurement would be limited.

4. Joint contracts would result in closing some pharmaceutical classes, which would be clinically unacceptable for certain populations.

5. DOD has limited control over private providers' prescribing practices.

The GAO reported that many of these obstacles can be overcome, and that DoUs use of the CMOPs would cut current dispensing costs and increase patient safety and convenience.

Compatibility of pharmacy records systems would allow the VA to fill prescriptions that are written by non-VA doctors. Currently, a VA doctor must review the patient's medical record and write the prescription for it to be filled at a VA pharmacy. DOD's direct care and retail pharmacies fill prescriptions from non-military providers, honoring prescriptions written by civilian licensed providers.. DOD's Pharmacy Data Transaction Service (PDTS) maintains a patient medication record, or profile, for all DOD beneficiaries to coordinate pharmacy delivery worldwide, Having common access to patients' health records, such as. PDTS could be the first step in permitting beneficiary access through both systems.

The Coalition recommends review of the pharmaceutical practices of both departments and their mail order pharmacies and urges improved cooperation between the two agencies in this area.

Market-Driven Strategic VA/DOD Collaboration

The Coalition is aware of a program currently in place termed the Central Region Federal Health Care Alliance (CRFHCA), whose focus is to foster collaboration between the Department of Defense, the Department of Veterans Affairs and the TRICARE Central Region managed care support contractor (TriWest Healthcare Alliance). This group has come together to maximize the use of federal resources in meeting the health care needs of all stakeholders. The Coalition believes that the CRFHCA model has great potential for immediate application in several local markets.

The first project is in Veterans' Integrated Service Network (VISN) 23, which includes North and South Dakota, Minnesota, Nebraska and Iowa. The TRICARE Lead Agent, the VISN Director, and the MTF commanders from Ellsworth AFB, Grand Forks AFB and Minot AFB, as well at TriWest Healthcare Alliance together are discussing specific areas for coordination to include sharing resources and services: catastrophic case management, telemedicine, radiology, mental health, data and information systems, prime vendor contracting, joint provider contracting, joint administrative processes and services, education and training. The next step is to expand to Colorado Springs later this year.

The Coalition urges the Subcommittees to examine the potential of an ongoing collaboration between Tri West Health Alliance, Veterans' Integrated Service Network (VISN) 23, and Military Treatment Facilities in the TRICARE Central Region for its potential as a model of strategic health care planning on a market-specific basis.

MID-TERM OPPORTUNITIES FOR DOD–VA SHARING

1. Procurement of medical/surgical supplies and equipment.
2. VA Medicare Subvention.
3. Access Standards and Coordination of Care.

Procurement of Medical/Surgical Supplies and Equipment

The Coalition believes that there is considerable potential for the two departments to jointly procure medical/surgical supplies and equipment. In general, purchasing in large quantities is more cost effective acquisition in lower numbers of units. Therefore, any opportunity for both agencies to combine their purchases of medical/surgical] supplies and medical equipment could lead to maximizing economies of scale for both agencies.

In regard to certain expensive, high technology items such as MRIs or CT machines, there may be a lack of market competition and little opportunity to maximize economies of scale; therefore, combined purchasing for these items may not provide a cost savings. However, areas where VA and DOD) facilities are collocated, sharing of equipment may be a more feasible option. If a institution has a high-ticket item such as an MRI unit that is not already operating at full capacity, incorporating beneficiaries from the other agency could lead to more efficient use of the equipment. The other agency would not necessarily have to purchase high-priced equipment to fill a limited need. Expensive technology that is used to its maximum capacity can justify significant acquisition investment.

The Coalition recommends development of a strategic plan for joint procurement of high cost equipment and supplies, consistent with each agency's mission requirements.

VA Medicare Subvention

In recent years, the House and Senate have passed VA subvention in separate sessions, but have not been able reach agreement on a design to test the use of Medicare funds in VA facilities. Medicare Subvention could prove beneficial to the government and stakeholders.

For veterans, VA Subvention would mean improved access to care, as nearly 60% of enrolled veterans are Medicare eligible. These beneficiaries have paid into Medicare throughout their working lives. One important question that needs to be evaluated is whether the VA can deliver Medicare-sponsored services more efficiently than Medicare in the private sector. A test would demonstrate whether Medicare funds already being spent in the private sector could be more efficiently used in the VA setting for Medicare-eligible veterans. The Coalition recommends a test to determine whether VA subvention can indeed deliver a "win-win-win" for Medicare, the VA health care system, and Medicare-eligible veterans.

Today, many Medicare-eligible veterans use VA health care for some services and Medicare HMOs or fee-for-service for the rest of their care. The result is inefficiency, duplication of effort, inconsistency, and patient safety concerns. A recent VA study revealed that the number of veterans who receive care from the VA and care from a Medicare HMO is "increasing rapidly." The study showed that:

• VA patients covered by Medicare HMOs already receive substantial amounts of VA care.

• Estimated Medicare payments to Medicare HMOs on behalf of veterans who seek care from both government providers were $305 million in one year (FY 1996).

• For veterans covered by Medicare HMOs for a one-year period (FY 1996), VA spending on Medicare services to those same veterans totaled $146 million.

VA data shows that enrollment of veterans in Medicare HMOs is increasing in areas of the country where VA resource allocations are decreasing. In the study, the proportion of Medicare-eligible VA patients enrolled in Medicare HMOs in the Northeast was up significantly. But in the corresponding VA networks, VA funding was on the decline. The study showed that Massachusetts Medicare enrollment increased from 3.0% to 12.2%; New York from 4.1% to 4.9%; New Jersey, 0.6% to 8.3%; and Pennsylvania, 2.3% to 13.2%.

VA Funding in the corresponding VA Networks from FY 1996–1999 was down: Boston (VISN 1), −8.0%; Albany (VISN 2), −5.8%; Bronx (VISN 3), −6.9%; Pittsburgh (VISN 4), −2.0%; Baltimore (VISN 5), −11.0%.

This may mean that overall government spending for Medicare-eligible veterans is simply being shifted away from the VA to Medicare in certain regions, with no gain in productivity.

In the context of rising Medicare enrollment and regional decreases in VA funding, a Subvention test would determine if veterans would choose VA health care as their primary source of care and if overall government spending for Medicare-eligible veterans' care could be reduced.

A VA Subvention test also would evaluate the economic dynamics in VISNs where there is rapid enrollment and funding growth. A test would determine whether government resources can be used more efficiently in regions with growing veteran populations. The same VA study showed that the proportion of Medicare eligible VA patients who are also enrolled in Medicare HMOs is significant in those areas where VA funding allocations are increasing.

The following table illustrates this:

PERCENT OF MEDICARE-ELIGIBLE VETERAN PATIENTS ALSO ENROLLED IN MEDICARE HMO

State	% VA patients also enrolled in Medicare HMOs	VISN Location	VERA Increases FY 96–99 (percent)
Arizona	30.5	Phoenix	+16.8
California	34.7	San Francisco	+8.8
		Long Beach	+4.0
Nevada	24.8	(3 VISNs overlap)	
Florida	20.7	Bay Pines	+16.1

Note.—VISN areas of responsibility do not correspond with State boundaries. Texas, Washington, Colorado, and Louisiana also have experienced significant growth in the number of VA patients enrolled in Medicare HMOs and VA funding increases in the corresponding networks.

The table suggests that in areas with rapid growth in the veteran population, the government may be providing resources for duplicate health care services for veterans. That's because veterans who are treated by Medicare providers must have the same or similar evaluations and diagnostics completed in the VA to obtain prescriptions or other services in VA facilities.

The Coalition continues to support testing the feasibility of using Medicare funds in VA facilities for the non-service connected care of Medicare-eligible veterans.

Access Standards and Coordination of Care

Differing access standards impede the two departments' ability to share resources. But the practical challenges of formulating appropriate reimbursement and cost-share mechanisms between DOD and VA are formidable. For example, a provision requiring DOD and VA to develop a reimbursement methodology for TRICARE patients receiving care in the VA was enacted under the Veterans Health Care and Benefits Act of 1999, but has yet to be implemented.

The VA does not currently have enforceable access standards for its beneficiaries, while DOD has a stringent three tiered access policy that the TRICARE Management Activity (TMA) must adhere to. The VA has seven enrollment priorities, but these have no bearing on appointments. All enrolled veterans compete on a first-

come-first-served basis. TMA, however, requires not only access standards, but appointment priority in Military Treatment Facilities (MTFs) is assigned to beneficiaries in relation to DOD's mission.

VA's seven priority categories for enrollment are the following:

1. Veterans with service-connected disabilities rated 50% or more.
2. Veterans with service-connected disabilities rated 30% or 40%.
3. Former POWs, veterans awarded the Purple Heart, veterans with service-connected disabilities of 10 or 20%, veterans discharged from active duty for a disability incurred or aggravated in the line of duty, veterans awarded the special eligibility classification under 38 USC, Section 1151.
4. Veterans receiving aid and attendance or housebound benefits, and veterans who are catastrophically disabled.
5. Nonservice-connected veterans and service-connected veterans rated 0% whose income and net worth are below the established dollar thresholds.
6. All other eligible veterans who are not required to make copayments for their care, including WWI and Mexican Border Veterans, veterans receiving care solely for disorders associated with exposure to a toxic substance, radiation, or for disorders associated with the service in the Persian Gulf, and compensable 0% service-connected veterans.
7. Nonservice-connected veterans and 0% noncompensable service-connected veterans with income and net worth above the established dollar thresholds and who agree to pay specified copayments.

PG 1–6 veterans fall under the "mandatory" care category, which means the VA must provide for their care subject to Congressional appropriation. PG–7 veterans, on the other hand, fall in the "discretionary" care category. The VA may provide for their care if Congress appropriates sufficient funds above the mandatory care requirements.

In its budget proposal for FY 2003, the administration asked Congress for an overall increase for veterans' health care while recommending that PG–7s pay a greater share of their care via an annual $1500 deductible. VA projects that approximately 120,000 of the 1.7 million PG–7 veterans will leave VA health care because of the deductible. Coincidentally, there are about 133,000 dual-eligible (TRICARE + VA) veterans enrolled in PG–7. If enacted, the proposal could cause considerable inconvenience for some dual eligibles, but won't hurt their pocketbooks. The government will simply shift the cost of their care from VA to DOD. Other PG–7 veterans with no other health insurance, including Medicare, won't be so fortunate, if the proposal is enacted. Most veterans groups are strongly opposed to "taxing" PG–7s and will be advocating other solutions, such as increasing the budget or allowing VA Medicare Subvention,

Readiness needs drive DODs appointment priority system in MTFs with priority assigned as follows:

1. Active duty members.
2. Family members of active duty members.
3. Retirees, survivors and family members.

The Coalition firmly believes that beneficiaries should maintain their access standards when they move between both systems. The Coalition is concerned that any efforts to merge the systems would result in DOD beneficiaries losing their established access priority, especially if they are forced to choose to receive their care solely at a VA facility. VA beneficiaries would lose out if DOD beneficiaries are brought in with their access priorities in place, then VA beneficiaries could be delayed in receiving their care. Both beneficiary populations are entitled to quality, expediently delivered care under their respective systems. The two departments must negotiate an acceptable access standard for use when beneficiaries move between the systems. Neither beneficiary group should have to seek care from a health system that cannot provide them timely access to quality care.

LONG TERM OPPORTUNITIES FOR DOD–VA COLLABORATION

The Future of Co-Located DoD–VA Facilities.

Future expansion of jointly managed facilities should be based on an impartial, external evaluation of existing programs. The Coalition does not subscribe to the theory that the current jointly managed activities demonstrate that future efforts must be organized under locally controlled "unified management systems" concepts.

The Coalition does, however, continue to support improving the capabilities of both systems at the corporate level in ways that will enhance efficient and effective service delivery locally. As challenging and frustrating as this process has been in the past, we believe real collaboration will not occur until common business proc-

esses are enabled, including billing procedures, accounting, information management/technology, medical data exchange, and so forth.

Because there has been no independent evaluation of current joint facilities activities, The Coalition proposes (as a minimum) the following guidelines to assess their progress:

- Access standards for affected beneficiary sub-groups;
- Analysis of the collaborative planning process within each joint facility;
- Command and control;
- Determination and allocation of staff;
- Enrollment and referral systems within each joint facility;
- Capital equipment investment and access rules·
- Formulary, pharmacy access, and pharmaceutical purchasing policies;
- Interoperable business systems: appointment, referral, billing, budgeting, cost accounting, medical records and information technology;
- Survey of healthcare outcomes for beneficiary sub-groups (disabled veterans, retirees, active duty servicemembers, PG–7 veterans, dependents) based on quality measures and patient satisfaction.

The VA plans to complete its Capital Asset Realignment for Enhanced Services (CARES) project over the next few years. During this period, DOD will likely commence preliminary planning for the next round of Base Realignment and Closure (BRAC process authorized by the FY 2002 National Defense Authorization Act.

The Coalition recommends incorporating an independent strategic assessment of current co-located facilities into CARES and BRAC planning.

H.R. 2667, the Dept. of Defense–Dept. of Veterans' Affairs Health Resources Access Improvement Act of 2001.

H.R. 2667 would authorize DOD and VA to test the integration of up to five co-located DOD and VA health care facilities. The Coalition supports the concept of more co-located DOD–VA facilities, but is concerned about demonstrations that could lead towards the ultimate merging of the DOD–VA health care systems. The Coalition is strongly opposed to merging or unifying DOD and VA health care.

With dramatic changes in beneficiary demographics over the next ten years, there may indeed be opportunities for more jointly managed facilities. On the other hand, the development of new technologies, non-invasive procedures, new drugs, and genetically based treatments may in fact reduce the need for substantial investment in "brick and mortar" health care facilities.

In addition, as noted above, the VA's CARES project and the DOD's next BRAC should incorporate joint facilities potential as part of their long-term planning processes.

The Coalition notes that the TRICARE and VA health care systems have evolved to the point where beneficiary health outcomes drive the quality of care, safety, and efficient service delivery in today's health care environment. Legislation to advance DOD–VA facilities' collaboration should identify the intended beneficiary outcomes as a measure of merit for joint facilities.

If beneficiary outcome measures are incorporated into the legislation, the Coalition can support the concept of testing facilities collaboration between DOD and the VA.

Concern Over "Unified Medical Systems"

The Coalition is particularly concerned over the concept of "unified medical systems" in H.R. 2667. Section 3(c)(2) of the bill would allow local VA executives and DOD commanders to execute a "unified staffing and assignment system for the personnel employed at or assigned to those facilities".

This proposal could wreak havoc on medical manpower planning in both the DOD and VA systems. Simply put, the proposal presumes that local arrangements should bypass corporate planning for medical and support staff.

DOD and VA patient populations have distinctively different characteristics and needs and the two systems have fundamentally different missions. DOD is primarily a primary-care, family focused "HMO" wellness model delivery system ranging from neonates to seniors. The VA, on the other hand, focuses primarily on geriatric, and other specialty care and research. We suggest the two should try to capitalize on the unique capabilities and advantages of each system in a partnership, while keeping in mind that the two are neither equivalent nor substitutable.

Coordination of Care: Unknown Under H.R. 2667

Section 3(g) of the bill proposes equalization of beneficiary payments between participating facilities, but overlooks the need to develop access standards for beneficiaries. A practical example of this dilemma is the marked difference in access

standards for TRICARE beneficiaries. Under the TRICARE Prime (HMO) option, TRICARE contractors must meet the following standards:

- Emergency Care (911 or Nearest Emergency Room)
  —24 Hours a Day, 7 Days a Week

  Timeliness of Appointments
  —1 Day—Acute Illness
  —1 Week—Routine Visit
  —1 Month—Well Visit or Specialty Care Referral
- 30 Minute Drive Time for Primary Care
- 60 Minute Drive Time for Specialty Care

Except for emergency care in civilian or VA hospitals for enrolled veterans who have used VA care, the VA system is not required to meet appointment standards comparable to TRICARE. In many cases, VA beneficiaries are forced to wait many months for appointments.

In addition, TRICARE sets priority for access based on the patient's status. In order, first priority goes to active duty servicemembers, then to active duty family members enrolled in TRICARE Prime, uniformed service retirees (enrolled in TRICARE Prime), then, active duty family members in Standard, and, finally, retirees in Standard. Reconciling these access standards and priorities with the VA system's previously mentioned "first-come, first-served" model is problematic in the face of finite resources.

The source statute for DOD–VA sharing agreements, Section 8111(d)(3) of Title 38 is not very helpful in this regard since it was enacted many years prior to sweeping reforms in VA and DOD healthcare over the past decade. Today, all enrolled veterans including "discretionary" veterans enrolled in Priority Group 7 have equal access to VA services. Neither disability levels nor other criteria impact access to care, once an enrollment is verified. Review of access standards for the VA system overall is an issue that we believe should be examined closely in the interest of all affected beneficiary groups.

The Coalition recommends amending H.R. 2667 to specify coordination of care standards for beneficiary groups and assure that benefits for all stakeholders are not diminished.

OTHER CONCERNS

Forced choice

As a matter of principle, the Coalition holds that all beneficiary groups who could be directly affected by closer DOD–VA medical resource sharing must preserve or enhance their current benefits. However, some administration officials continue to support a budget-driven proposal that would compel military retirees to relinquish either their DOD or VA health care benefits.

The press release announcing the President's signature of the VA–HUD Appropriations Act for FY 2002 (P.L. 107–73) acknowledged the prohibition against using funds to implement "forced choice." But the administration insists forced choice remains a good idea: "The VA/DOD Medical Care Choice initiative would ensure that all military retirees annually choose either the Department of Defense or the Department of Veterans Affairs as their health care provider. This would enhance quality and continuity of care and prevent duplication of services and costs."

DOD and VA care are significantly different, in terms of their services and the population served. Many retirees are willing to drive long distances to obtain specialized VA care for spinal injuries, prosthetics, etc., but obtain their routine care through local doctors under the TRICARE system. The Coalition believes strongly that they earned access to both systems and should not be forced to give up one or the other.

House and Senate conferees to The FY 2002 National Defense Authorization Act did the fight thing by including a provision (Section 711) in the law that prohibits DOD from requiring retirees to obtain their government-sponsored health care solely from that Department.

Certainly there are opportunities to improve the coordination of benefits between the two systems, especially for retirees enrolled in the "discretionary" care enrollment category—Priority Group 7. Indeed, implementation of TRICARE for Life (TFL) may eventually reduce enrollment in PG–7 of Medicare-eligible retirees with no disabilities and higher incomes One area for potential improved coordination is for DOD and VA to resolve reimbursement and billing policy and procedures for dually eligible PG–7 enrollees.

The Coalition strongly recommends the Subcommittees uphold the principle that military retired veterans have earned and deserve access to both VA and DOD care systems and they must not be forced to forego either benefit. Budget driven propos-

als should be resolved by the DOD and VA and not visited on the backs of those who earned those benefits through service to their country.

Accountability

Among the most important strategic issue to be considered in any planning for collaboration is accountability. A DOD beneficiary who encounters difficulties in resolving claims or resides on areas with limited access to TRICARE authorized provided, can consider the multiple chains of command in the Defense Health System as a complex system with a lack of accountability and no one in charge of their care.

In order to obtain care, DOD beneficiaries in the United States may have to resolve their issues with several bureaucracies: DOD Health Affairs, the TRICARE Management Activity, 11 TRICARE Regions administered by 11 military Lead Agents and managed by 4 different contractors using a variety of subcontractors and 2 claims processors, their military Service medical commands, and finally, at the local level, the leadership of their MTF.

The Coalition strongly urges caution before adding another complex bureaucratic system with 22 VISNS, 173 hospitals, and several hundred CBOCs into these beneficiaries' health care delivery options. If a DOD beneficiary's Primary Care Manager (PCM) writes a specialty referral, and the MTF Health Care Finder makes an appointment with a provider in the VA, which agency will be held accountable should records get lost or a test is not properly authorized? Which agency would be accountable for resolving the issues for the beneficiary? In this type of scenario, beneficiaries must have an ombudsman to help them deal with the multi-agency bureaucracy.

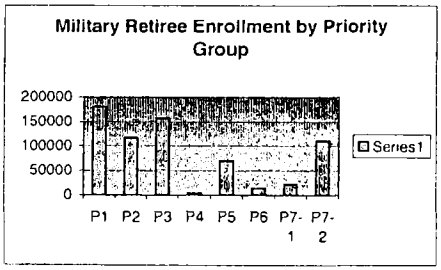
Demographic Tracking of Dual-Eligibles

Eligibility reform, open enrollment, and improvements in quality of care and safety have had a dramatic impact on VA health care. At the end of FY 2001, there were more than 5 million veterans enrolled in VA health care. The fastest growing category is Priority Group 7.

Six hundred seventy-seven thousand (677,000) enrollees are military retirees, but their reliance on the VA as a primary source of care is not known. Overall, demand for VA services is stretching capacity at many local VA facilities and reducing access for eligible beneficiaries, including military retirees.

The following chart depicts graphically the distribution of retired veteran enrollees in VA care. It shows that:

- over 80% of retired veterans qualify for "mandatory" VA care under the law;
- more than two-thirds (67%) of enrolled retired veterans have VA-rated disabilities, were wounded in combat (Purple Heart), or are former POWs. (PG 1–3).



However, the number of enrolled retired veterans who actually use the VA as their primary source of care is not known. The VA system tracks "unique" visits only; an enrollee who makes a single visit is counted as a "unique" patient. Retirees who apply for a VA disability rating must encounter the VA system at least once for the rating physical. These veterans are automatically enrolled, whether or not they subsequently use VA health care routinely. From the available data, it appears that more severely disabled retired veterans rely more on VA care, especially for its specialty care expertise in areas like spinal cord injury, blind rehabilitation, PTSD, and prosthetics.

The Coalition recommends development of better data on military retiree usage of VA care in order to obtain a more accurate picture of demand and cost on that system and improved reimbursement planning between DOD and VA.

CONCLUSION

Both DOD and the VA have reported through the Executive Council on ways they are collaborating in contracting, administrative and maintenance services, and purchasing. The Coalition is hopeful that these arrangements, if properly administered and evaluated, could provide models for future collaboration. We believe the two systems can and should work closer together to develop health care quality measures, graduate medical education, and centers of excellence for certain specialty care. The Coalition requests, however, that the Subcommittees encourage collaborative ventures as part of an overall strategic initiative with a primary focus on the needs of each system's beneficiaries.

Leadership and planning at the Department level must be translated to empowerment of local DOD and VA staff. Leadership at the top and empowerment at the local level are critical in order for VA/DOD's collaboration efforts to succeed. In visits to several joint ventures, Coalition representatives were impressed with the DOD and VA local staffs' ability to overcome obstacles, thus demonstrating their commitment at the grassroots level to make the ventures successful. Unfortunately, we also concluded that these programs were based on an over-reliance on local staffs' personal commitment, rather than on the support, facilitation, and guidance available from the senior leadership level. Certain issues, especially those involving budgeting, technology, and funds transfers, were problematic in each facility.

Before determining which facilities should be co-located, or how pharmacies or the pharmacy formularies could be integrated, the Coalition recommends an examination of the service delivery of two different benefits to two disparate beneficiary populations in the context of two very distinct missions. We recommend a strategic evaluation at the highest levels of government as to: what changes are needed at the department level to facilitate cooperation and what support is needed to empower local leaders to engage in successful collaborative efforts.

Local VA and DOD staff cannot solve the systems issues encountered at current joint ventures. Leadership and resources at the headquarters level are essential to bring compatibility to pharmacy transactions, patient records, claims processing, and other administrative activities. Without support at the top and empowerment at the grassroots, the recommendations of this Subcommittee along with the many commissions that have looked at this issue will go unheeded.

The Coalition is encouraged by the initial work of the Presidential Task Force to Improve Health Care Delivery to our Nation's Veterans (PTF). Since October of 2001, the PTF has undertaken a methodical evaluation of:

- ways to improve benefits and services for VA and DOD beneficiaries through better coordination of the activities of the two departments;
- a review of barriers and challenges that impede coordination and to identify opportunities to improve business practices to ensure high quality and cost effective health care; and
- opportunities for improved resource utilization through partnership between both agencies.

It is the Coalition's expectation that with support from the Administration, both agencies will move forward with greater collaboration to enhance the delivery of quality health care to beneficiaries who have earned health care benefits through service to their country in uniform.

The Coalition is eager to see increased efforts to improve DOD/VA coordination. However, these activities must at a minimum enhance or maintain access to health care, quality, safety, and services offered to each category of beneficiaries. The final outcome must improve or preserve benefits at the same level for all stakeholders. No conclusions should be made, regardless of how efficient they may appear, unless it is clear that all beneficiary groups will not be negatively impacted. We firmly believe the answer lies in greater collaboration, not integration, of these two systems with unique missions and divergent populations.

Thank you very much for the opportunity to present the Coalition's views on these critically important topics.

STATEMENT OF THE NATIONAL MILITARY AND VETERANS ALLIANCE, PRESENTED BY DIERDRE PARKE HOLLEMAN, DEPUTY LEGISLATIVE DIRECTOR OF THE RETIRED ENLISTED ASSOCIATION

INTRODUCTION

Mister Chairmen and distinguished members of both Committees the National Military and Veterans Alliance (NMVA) is very grateful for the invitation to testify before you about our views and suggestions concerning possibilities for improved co-

ordination between the Department of Defense' and the Department of Veteran Affairs' Health Care Systems.

The Alliance was founded in 1996 as an umbrella organization to be utilized by the various military and veteran associations as a means to work together towards their common goals. The Alliance's organizations are:

American Military Retirees Association
American Military Society
American Retiree Association
American World War II Orphans Network
AMVETS National Headquarters
Catholic War Veterans
Class Act Group
Gold Star Wives of America
Korean War Veterans Foundation
Legion of Valor
Military Order of the Purple Heart
National Association for Uniformed Services
National Gulf War Resource Center
Naval Enlisted Reserve Association
Naval Reserve Association
Non Commissioned Officers Association
Society of Medical Consultants to the Armed Forces
Society of Military Widows
The Retired Enlisted Association
TREA Senior Citizens League
Tragedy Assistance Program for Survivors
Uniformed Services Disabled Retirees
Veterans of Foreign Wars
Vietnam Veterans of America

The preceding organizations have almost five million members who are serving our nation, or who have done so in the past and their families.

The National Military and Veterans Alliance receives no grants or contracts from the U.S. federal government.

THE GOAL OF DOD AND VA SHARING AND COORDINATION

When decision makers look at the goal of coordinating the health care services of the Department of Defense and the Department of Veteran Affairs their first thoughts are to avoid duplication of effort and thus create financial savings. Both are worthy goals. But while hoping for these results one should abide by the Hyppocratic oath and say: "First do no harm." The Departments should only assume this huge effort if, at all times, the main goal is to improve health care for all beneficiaries while keeping both Departments' purpose and Missions always in the forefront of their programs. It is crucial that any plan for coordination leaves both sets of beneficiaries with, at least, the same level of benefits and services they now enjoy or, hopefully, enhanced benefits.

The Missions of the two Departments Health Programs are quite different. At first glance they may look the same: PROVIDING QUALITY HEALTHCARE. The Department of Veteran Affairs' Mission clearly is to provide quality medical care for our Nation's Veterans. The Department of Defenses' Mission is two fold: (1) to support readiness of active duty troops and to have skilled and mobile medical staffs ready to support and follow the active duty troops where ordered and (2) to provide first class medical care for the active duty members' families, Military retirees and their survivors. The second part of DOD's health care mission helps to support readiness by improving the morale and peace of mind of the active duty forces. It further enhances recruitment and retention by improving the quality of life for the Active Duty families and assuring all stakeholders that DOD will keep faith with the promises made to former Military members and their families. Thus the two Departments have very different goals and populations who they serve and these differences are reflected in how the two health care systems have developed. Any plan for sharing, coordination and cooperation must take into account the two separate focuses when deciding if any proposed plan is workable.

One of VA's focuses while providing health care is providing medical education and conduct extensive medical research. In 2001 the VA's academic affiliates trained over 85,000 doctors. Along with financial support the VA attracts doctors by sponsoring first class medical research in the areas of spinal cord injury, mental health and prosthetic development. Such renowned programs should be maintained or enhanced while cooperative plans are being designed.

For many years there have been numerous calls for the Department of Defense' and the Department of Veterans Affairs' health programs to coordinate their services. The results have repeatedly been huge disappointments. When people tried to understand why the cooperative models did not generally work (There have always been local sharing projects that have been inspiring successes but they have not been taken up by other areas of the country and other facilities.) the answer was that it was not "really tried." However, the experiments have been tried by people of good will but still the results have been disappointing. As stated above, the reason may be that the two programs are not as similar as they first may appear; thus their coordination is harder than predicted and may not be possible in all areas of their endeavors. However, that does not mean that useful coordination is not possible. To decide where we can improve the operation of both Departments we must analyze the programs carefully and see where to start.

History makes clear that for the collaboration of parts the Department of Defense's and the Department of Veteran Affairs' health care mission to be successful the direction to coordinate must come from the highest levels of both Departments. It must be made part of the Mission of all responsible members of both Departments. It must come from the top down rather than from an enthusiastic true believer at the local level. Many test programs have been started by such an individual in the last 20 years only to wither away when that person was transferred to a different assignment.

The Presidential Task Force is presently looking at possible systemic changes that may help improve health care for all beneficiary groups and improve the administration of both Departments' programs. In the short run there are some areas where there is presently widespread agreement among representatives of Veteran Service Organizations and other Veterans and Military Retiree Groups that coordination is possible and could benefit both groups of Beneficiaries and both Departments' efficiency, budgets and employees' morale. These include: Information Technology (IT) coordination, the pharmacy programs, billing and claim coordination, Department of Veteran Affairs and Department of Defense Medicare subvention; the Department of Veteran Affairs as a TRICARE provider; coordination of Military Treatment Facilities (MTFs), TRICARE Contractors and Veterans Integrated Service Networks (VISNs) in certain regions; and DOD/VA co-located facilities.

INFORMATION TECHNOLOGY (IT)

To start to meld the medical practices we must first look at the IT (Information Technology) that could allow the two Departments' Medical staffs to speak to each other. Before we can coordinate medical treatment we must first be able to transfer patients' medical records information back and forth between DOD and the DVA. At this time we can not do so. In January 1998, the Government Computer-Based Patient Record (GCPR) project was commenced by DOD, the VA and IHS. In that same year President Clinton directed DOD and the VA to create a joint computer patient record system. Although a great deal of time and energy has been spent on the project it has been slow going—target dates have not been met and no implementation date presently exists. It has also had steep cost overruns. But the goal itself is essential. While this work must be successful before true and comprehensive coordination can take place, in the short run the Departments may start by creating a common DOD/VA separation physical. Such an exam using a newly developed software program can record all the information needed by both DOD and the VA. The needed information VA could then be electronically transferred to the VA vitiating the need for a second physical conducted by the VA. And this could be the start of a uniform medical recordkeeping system

It has been the long term hope that part of the growing costs of medical treatment in both the Department of Defense and the Department of Veteran Affairs could be paid by billing private insurance companies and Medicare/Medicaid systems (DOD and VA Subvention). Numerous attempts to improve these financial streams have failed. In part this failure has been caused we believe because the various systems do not share the same system for claims and billing. Since the 800 pound gorilla in all medical claims in the country is clearly Medicare if DOD and the DVA adopted the Medicare claims system ALL parties—Private Insurance Companies, DOD, the DVA and Medicare/Medicaid would know what medical services, pharmaceuticals, laboratory services and the like have been provided. Such a uniform billing plan could also lead to improvements in allowing the VA to be a fully participating TRICARE network provider. This does not solve the other billing problems but at least it would put all the parties on the same page of the hymnal. Other areas that DOD and the VA are presently working on in IT development include Technology Integrated Laboratory, Interagency Pharmacy Initiatives, Health Data Re-

pository, Centralized Credentials Quality Assurance Systems. All these projects should be looked at as steps toward further cooperation and better beneficiary.

PHARMACY, MAIL ORDER DRUGS AND DRUG PURCHASING

The present area of endeavor where everyone who has studied this problem sees possibilities of quick coordination and possible cash savings in the area of drug purchasing and distribution. The General Accounting Office reported in May, 2001 that DOD and the VA spent $3.2 billion on prescription drugs in fiscal year 2000. With DOD's newly added Senior Pharmacy benefit's estimated yearly $88 million cost the two Departments will be spending over $4 billion this year on prescription drugs. If savings could be found it would relieve some of the financial pressure on both systems. This is the area that can be acted upon very quickly. Any day (if not already) the Department of Defense will issue a RFP for its National Mail Order pharmacy (NMOP). The Department of Veteran Affairs already has a renowned Consolidated Mail Order Pharmacy (CMOP) to issue refills of their prescriptions through the mail. If the two different formularies could be combined (differing beneficiary populations—women and children for DOD and elderly patients and mental health treatments in the VA) this could mean possible savings in negotiated drug prices and predictable savings in distribution costs. However, again creating a single formulary will be a great challenge. At the direction of Congress the Department of Defense will very shortly release their proposal for a uniform formulary. Of course then there will be vigorous discussions about the plan. The VA already has a broad formulary. But both formularies will be looking at different populations. DOD covers numerous women of all ages and children (though the commencement of TRICARE for Life has required DOD to look at over 65 beneficiaries' medical needs. The VA has always focused on an older male population (though the increase of women in the active duty will require a change in that point of view as well.)

As discussed before the two programs are different in mission and structure. A difference that does not seem to be mission grounded are the rules governing the two Departments' pharmacies. These differences have very practical every day effects on the members of the two groups of beneficiaries. When people need drugs quickly mail order pharmacies are no help. They must look to their neighborhoods. At the present time, the VA Pharmacies, which are located across the nation, can only issue prescriptions that have been written in their facilities. If this rule could be changed to allow VA pharmacies to fill prescriptions for TRICARE patients regardless of which Doctor wrote the script the Department of Defense could save substantial money by having a practical option for their beneficiaries other than their TRICARE Network Pharmacies. However, before this could be safely accomplished the Departments would have to develop a method to allow the VA system to have access to DOD's electronic Pharmacy Data Transaction Service (PDTS). If this is done it would save money for the Department, it would make life easier and less expensive for active duty families enrolled in TRICARE Prime Remote due to assignment and retirees who are scattered throughout the country. Finally, this one change could also help the VA because if the VA beneficiaries could have their private physician's prescriptions filled by the VA pharmacies the huge influx of patients requiring in house appointments merely to qualify for a prescription, or to renew a maintenance drug prescription could be vastly reduced.

By developing a uniform formulary, by opening up distribution points to both beneficiary populations, and by possibly combining their mail order programs (as a long term goal) the Department of Defense and the Department of Veteran Affairs could improve the service for their beneficiaries; could save wear and tear on their employees and could hopefully save money for both Departments.

JOINT PURCHASES OF HOSPITAL/CLINICS'S SUPPLIES AND SERVICES

While looking at pharmaceutical costs and purchases we should not miss other joint purchases that also may save money and save time and effort of double contracting. This can include medical supplies, laundry services, maintenance and janitorial services (if security concerns will allow) and surgical supplies. Increasing the size of these contracts from area to area can save money and time while not changing the focus or the mission of each facility. Buying in bulk is usually a saving idea.

JOINT OWNERSHIP OF EXPENSIVE MEDICAL EQUIPMENT

Another area of possible savings and efficiency is the joint purchase and coordinated use of expensive diagnostic tools. If distances and treatment permits the sharing of diagnostic and other sophisticated medical equipment provides convenient care for patients and maximum use for important investment. This is presently being done throughout the country among closely located civilian hospitals. How-

ever, whenever such a sharing agreement is considered the Medical personnel must be sure that the distances and delays involved in traveling from facility to facility is recommended. (Example if a patient needs a CAT Scan is it appropriate to drive 30 minutes from the MTF to the VA Facility. This is the sort of decision that must be made by medical personnel, not administrators.)

TRICARE ACCESS STANDARDS AND THE VA

When discussing medical supplies and equipment purchases or drug distribution the savings will not be visible to the beneficiaries. But when the consideration of sharing or coordination of health care in the Departments' facilities then the affected beneficiaries will be looking at two very different benefit plans. TRICARE Prime beneficiaries have guaranteed access standards. It is an entitlement. While care at the VA is discretionary. For a TRICARE beneficiary to be treated in a VA facility an appointment must be made within 24 hours for urgent care; within seven days for routine care; within thirty days for referred or specialty care and wellness and preventive care. It is well known that the VA has no such access standards for their beneficiaries. Veterans have been known to wait for months for some types of appointments. Therefore it must be clearly planned from the top—how will the last appointment for the day be assigned? Who will be bumped? When we all speak about the need to at the least maintain the present levels of service for all beneficiaries this is the crux of the matter. How can this be done fairly? How can we avoid disadvantaging a beneficiary? If a general plan cannot be developed then we will be left with local agreements where there is enough staff and space to accommodate both systems. Additionally, the Alliance wants to reemphasize our strong position against the idea of forced choice for military retirees. We were very pleased that Congress stated their clear disapproval of the concept in 2002's VA's Appropriations Bill and DOD's Authorization Act. It is crucial to understand that the military retiree has earned these two very different benefits for very different reasons. Furthermore many retirees use the benefits for very different reasons as well. A retiree may chose to take advantage of the VA's expertise concerning injuries to have a service connected injury treated at a distant VA Hospital. He then may use TRICARE for his primary care near his home. It is his choice today and it should remain his choice.

DOD AND VA SUBVENTION

As briefly mentioned above, the attempt of Medicare subvention (having Medicare pay for treatment of its beneficiaries at MTFs) with the DOD has been a huge disappointment. The Department of Defense has received no stream of payments. Medicare's required "level of effort" has never been reached by an MTF. But this goal should not be abandoned. The active duty member, his or her working spouse, the Veteran and the Military Retiree have all spent their working careers paying money into the Medicare system. The taxes have been paid but if they receive treatment in a MTF or a DVA hospital or clinic the facility receives nothing from Medicare to help pay for that beneficiary and taxpayers. Of course, the people sworn to protect the Medicare trust fund like the situation as it is. And who can blame them? However the financially strained medical systems of the VA and DOD should receive some of the support their patients have paid. Again, if DOD and the VA adopted Medicare's billing system it could support an effective attempt at subvention.

THE DEPARTMENT OF VETERANS AFFAIRS AS A TRICARE PROVIDER

One of the areas where coordination by the DOD and DVA could occur almost immediately is by making VA installations active TRICARE providers. At this time 80% of Veteran Affairs installations are nominally TRICARE providers in the TRICARE Networks. However, last year TRICARE paid only $3.7 million to VA facilities for care provided to TRICARE beneficiaries. Part of the problem is clearly the previously discussed failure to have one system of Medical Record keeping and one method of claims and billing. Therefore, the change suggested above to follow Medicare's claims and billing system could alleviate some of the problems. It is also crucial to solve this problem so that the VA can qualify to be a TRICARE for Life provider. It could be a way to help improve coordination and predictability as well as a cost saving for both the DVA and DOD if the VA became a qualified Medicare provider. If this was accomplished then Medicare Part A or Part B would be first payor and TFL would pay the rest. This could be a serious stream of money (primarily from Medicare) to the VA for non-service connected treatment that the VA provides to military retirees. But unless and until the VA qualifies as a MEDICARE provider this is not possible. Since the door has been opened to coordinate Medicare payments and TRICARE by the coordination of their benefits in TRICARE for Life

this would be a coordination that should make sense for all three Departments and would most importantly, improve the treatment of many beneficiaries.

JOINT MTF/VISN/TRICARE CONTRACTOR PROJECTS

When looking far into the future we can see coordinated networks for a region's Military Treatment Facility (MTF), its Veterans Integrated Service Network (VISN) and the civilian TRICARE contractor. This would actively use the VA as a provider of specialty health care, save money for DOD and plan a core of coordinated services A test program in the Central TRICARE region called the Central Regional Federal Health Care Alliance has just been rolled out to look at, and coordinate areas of practice including possibly: "catastrophic case management, telemedicine, radiology, mental health, data and information systems, prime vendor contracting, joint provider contracting, joint administration processes and services and education and training." The governing board's members of this experiment include DOD's Lead Agent for the Region, VA's VISN Director and the president and CEO of the Region's TRICARE Contractor. If this plan succeeds in improving the health care of the beneficiaries and, hopefully, saving money for the taxpayers perhaps its form can be transported or modified for other regions.

CO-LOCATED DOD/DVA FACILTIES

An area that DOD/DVA sharing advocates can presently point to with pride is shared or contiguous sites. Where geography and planning allow these have been very helpful. When looking into the future we must consider these and any future projects when considering BRAC and CARES closings. A major investment of time and money should not be made in an area where changes may quickly make the institution obsolete.

CONCLUSION

It is clear that there are areas of management, purchasing, providing of health care and administrative efficiencies where coordination of the practices of DOD and the DVA Health programs could yield huge benefits for the beneficiaries and the Departments. But such coordination must be instituted with caution; with an eye to the different missions of the two institutions, the differences of the two populations being served and the acknowledgment that changing the path of an aircraft carrier is a much more delicate task than it first might appear to be.

BIOGRAPHY OF DEIRDRE PARKE HOLLEMAN

Deirdre Parke Holleman, Esq. is the Deputy Legislative Director of the Retired Enlisted Association. She is responsible for TREA's legislative agenda health care and survivor issues. Additionally she serves on the Department of Defense's Oversight Advisory Committee for Chiropractic Health Care Implementation, the Department of Defense's Working Panel for Implementation of TRICARE for Life and on numerous other committees.

Before joining TREA Mrs. Holleman was the Washington Liaison for The Gold Star Wives of America, Inc. In that capacity she represented GSW's concerns and legislative goals before Congress, the Administration, the VA and to fellow Veteran Service Organizations.

Mrs. Holleman is an attorney licensed to practice in the State of New York and before all Federal District Courts, the Second Circuit Court of Appeals and the United States Supreme Court. She was the Associate Director of the Legal Aid Society of Mid-New York Inc. This independent not-for-profit law office represents the poor in civil matters over nine counties of upstate New York. She has a B.A. in history and journalism from George Washington University and a J.D. from Vanderbilt University School of Law.

She is married to Christopher Holleman, an Administrative Judge for the U.S. Small Business Administration.

STATEMENT OF STEVE ROBERTSON, DIRECTOR, NATIONAL LEGISLATIVE COMMISSION, THE AMERICAN LEGION

Mr. Chairmen and Members of these Subcommittees:

The American Legion welcomes the opportunity to provide testimony regarding the Department of Veterans Affairs (VA) and Department of Defense (DOD) health

care sharing. The American Legion applauds the efforts of these committees to hold a Joint hearing on such an important issue.

Access to both VA's and DOD's integrated health care system is an earned benefit from a grateful nation based on military service. Although there are many dual-eligible veterans, VA's and DOD's integrated health care system have unique mission with some degree of overlap. For this reason, the American Legion adamantly supports maintaining each independent integrated health care system, while seeking opportunities for joint ventures, resource sharing opportunities, and other areas of cooperation.

DOD's primary mission is providing quality health care to maintain military readiness. VA's primary mission is providing quality health care for America's veterans, especially those with service-connected disabilities. DOD's patient population includes a significant number of spouses and children. VA's patient population includes a very limited number of spouses and children. VA offers an array of specialized services, such as blind rehabilitation, long-term care, spinal cord and brain injury, and others. DOD offers few specialized services. Therefore, it would be unwise to ask any military retiree to choose between the enrollment in one integrated health care system or the other. However, these distinct diversities also offer ample health care sharing opportunities.

With the advent of the first joint venture and the emergence of VA and DOD medical sharing agreements, The American Legion established its own Special Task Force on Veterans' Medical Care to review the effectiveness of these cooperative efforts. The Task Force's initial report of September 1989 stated that the sharing agreements, "represented positive adjuncts to efforts to meet the mission of medical centers. They enhance the availability and variety of services provided to veterans, and they can provide avenues to increase joint education and research endeavors." The American Legion continues to believe in and support these efforts. The American Legion recognizes the current benefits from these sharing agreements and the potential gains from additional efforts. Sharing agreements augment services and build on the respective strengths of the participants.

VA and DOD medical systems are the largest federal health care providers in this country. In Fiscal Year (FY) 2001, Veterans Health Administration (VHA) had a $20.7 billion medical care budget. VA has 172 medical centers, 900 ambulatory clinics, 134 nursing homes, 40 domicilaries, 72 comprehensive home-care programs, and 206 counseling centers. In FY 2001, DOD had a $18.21 billion medical care budget. DOD has 15 medical centers, 66 Community Hospitals, and 489 clinics. Combined, the two agencies have 14 million enrolled beneficiaries. Clearly, there are many opportunities for sharing.

Currently, VA and DOD sharing occurs among 165 VA Medical Centers (VAMC) with most military medical treatment facilities and 156 Reserve units around the country. VA and the military have agreed to share 6,602 services covering a broad range of hospital related activities. However, this represents a decrease of over 1000 services shared from the year 2000. One of the problems cited is DOD's TRICARE managed care contract structure does not promote the use of government agency resource sharing. Both Departments are exploring ways to improve and increase coordination of service delivery in many areas such as long-term care, pharmacy, chiropractic services, and joint ventures.

There are seven joint venture sites where VA and DOD are co-located on the same campus:

- VA New Mexico Health Care System (HCS) & Kirkland AFB (Albuquerque, NM)
- El Paso VAHCS & William Beaumont Army Medical Center (EI Paso, TX)
- VA Key West & Navy (Key West, FL)
- VANCHCS & Travis/Mather AFB (Fairfield, CA)
- Tripler Army Medical Center & VAMROC Honolulu (Honolulu, HI)
- Nellis AFB & Southern Nevada VAHCS (Las Vegas, NV)
- Elmendorf AFB & VAMROC Anchorage (Anchorage, AK)

With the start up of the hospital at Elmendorf AFB, all of the planned joint ventures are on line. Unfortunately, no other new Joint venture initiatives have emerged in the past several years, yet demand for services continues to increase. This may be attributed to the lack of construction dollars and other resources required to bring a facility up to code. Yet leadership at both VA and DOD appear to be motivated to institute new joint ventures. It would seem an opportune time for DOD to co-locate TRICARE providers at VHA facilities or have VHA primary care clinics on more military installations.

EXISTING BARRIERS

Both VHA and DOD have explored joint ventures with measured success. Clearly, there are barriers—some are tangible, but most appear more philosophical or cultural. Strong management at the local level can readily identify tangible barriers and offer creative solutions, but overcoming philosophical or cultural barriers will require focused leadership. Faced with the prospects of yet another round of the base realignment and closure (BRAC) recommendations,

DOD stands to lose additional military health facilities from Its inventory. Since the first BRAC, DOD has lost over 50 percent of its military hospitals. VA is currently undergoing its own version of BRAC, the Capital Asset Realignment for Enhanced Services (CARES). Each Department would be well advised to remain vigilant for the opportunity to enter into joint ventures. Neither downsizing program seems to give serious consideration to the adverse impact on the health care delivery of the veterans' community as a whole.

The American Legion realizes that sharing does not necessarily resolve partners' problems. In New Mexico, VA was not able to rely on the Air Force to help resolve its serious nursing shortage because DOD has downsized and has less authorized nursing positions. Dental service at VA receives support from Kirkland's dental clinic, but is not a source for resolving VA's increase in waiting times. Partners entering into the joint venture need to be able to share their strengths for the partnership to be mutually beneficial.

Another common physical barrier between VA and DOD is the information technology communication gap. The information technology disconnect between Departments severely restricts seamless transmission of critical information. Current technology exists to establish and maintain electronic medical records capable of storing all data collected in a Federal health care facility. This would help expedite VA's claim and adjudication process by making military medical records immediately available to provide documentation of service-connected injuries or medical conditions.

Another information technology function commonly found throughout the health care industry is the billing and collection of third-party reimbursements. Yet, this fundamental process between VA and DOD, especially its for-profit health care contractors—TRICARE—is extremely problematic. Electronic billing and collection are routine transactions between health care provider and health insurance payers. VA's ability to properly bill and collect from third-party insurers continues to lag behind the Federal discretionary budgetary expectations. This revenue shortfall adversely impacts on VA's health care delivery capabilities and limits the cooperative opportunities for TRICARE's subcontracting options as well.

Currently, VHA is directed to bill and collect third-party reimbursements for the treatment and services provided to all veterans for nonservice-connected medical conditions. In VA, the enrollment of Priority Group 7 veterans is contingent on their ability to pay for treatment and services received. However, if the Priority Group 7 veteran is Medicare-eligible, VHA is not authorized to bill Centers for Medicare and Medicaid Services (CMS) for the treatment of nonservice connected medical conditions, even if the condition is normally covered by Medicare. The veteran is required to pay the co-payment. Any other third-party insurance coverage, including the Medicare supplemental insurer, will also be billed. In essence, VHA subsidizes CMS.

The annual VA medical care discretionary appropriations are offset by the projected collections from such third-party insurers, yet no funding credit is awarded for the treatment of enrolled Priority Group 7, Medicare-eligible veterans treated for nonservice-connected conditions. In a joint venture facility, under the new TRICARE for Life provision, this creates internal billing problems for Medicare-eligible military retirees referred to VA by TRICARE providers. Under the conditions of TRICARE for Life, the enrolled Medicare-eligible patient must purchase the Pan B supplemental coverage. TRICARE subcontractor must bill Medicare. then the Medigap insurer, and finally DOD for any remaining charges. If VA is a subcontractor for TIRCARE and cannot bill Medicare" DOD has a disincentive to send Medicare eligible patients to VA facilities because of the additional cost to DOD.

Access to VA and DOD health care is an earned benefit based on honorable military service—not age. Medicare coverage is based on a totally different set of criteria. Both Medicare options (fee-for-service and Medicare+Choice) could be effectively administrated within VA. Using Medicare's own performance standards for the treatment of certain health care conditions, VHA has repeatedly exceeded Medicare's expectations.

Most successful sharing agreements between VA and DOD have been reached at the local level due to budgetary necessity. The key elements are quality communica-

tion and coordinated strategic planning. The principal objective is delivery of quality health care rather than pride of ownership. Maximum utilization of available federal resources should be an element in annual individual performance evaluations. Positive reinforcement should be awarded for stellar performance. Again, with the real prospect of another BRAC coupled with impending CARES recommendations, both Departments should seek sharing agreements to maximize available health services for their patient populations. American Legion representatives have visited several joint venture campuses. Each Joint venture has its own strength and weaknesses, but their ultimate goal is the same—delivery of quality health care to its beneficiaries.

COOPERATION

A commonly identified opportunity for closer VA and DOD cooperation is joint purchasing ventures for pharmaceuticals, medical supplies, and equipment. Utilizing economy of scales would enhance the buying power of scarce Federal discretionary dollars. Joint partnerships for contracting of pharmaceuticals have met with very agreeable results. VA and DOD have 55 national contracts and three Blanket Purchase Agreements (BPAs). VA saved some $85 million from these contracts and BPAs in 2001 while DOD saved over $100 million in the same year for all national contracts. To date, VA and DOD have identified 50 drugs that may have joint contracting possibilities in 2002.

This initiative, coupled with joint ventures and sharing agreements, would enhance coordinated purchases of expensive equipment and help reduce incidents of excess regional purchases. The American Legion would like to see an emphasis on more sharing opportunities considered with pharmaceuticals and medical/surgical supplies.

VHA's reputation in medial and prosthetics research is stellar. VHA is also recognized as the largest trainer of health care professionals. This creates a logical opportunity for closer cooperation and coordination between VA and DOD to result in a win-win scenario. Through its affiliation with medical schools and academic medical centers, as well as other research institutions, VHA continues as a major national research asset. VHA conducts basic clinical, epidemiological and behavioral studies across the entire spectrum of scientific disciplines. In recent studies, VRA's patient safety procedures have received national recognition for excellence. In terms of nuclear, chemical, and biological warfare, MHS remains the nations' leading expert in casualty care. Both systems would benefit from shared expertise and best practices in these and other areas.

The events of September 11, 2001 emphasize the national need for improved emergency preparedness for combat and civilian casualties. A major VHA mission is to serve as a contingency back-up for DOD medical services and support the National Disaster Medical System. Clearly, close cooperation between VHA and DOD on a daily basis greatly enhances the knowledge of and confidence in the capabilities of each Department.

NEAR-TERM GOALS

• Coordinated purchasing—A renewed focus on Joint efforts between the two agencies to share services and purchases of medical/surgical and pharmaceutical supplies.

• Enhanced sharing agreements—The American Legion would like to see maximum utilization of sharing agreements between all regional VA, DOD and TRICARE health care providers.

• Implemented Medicare subvention—The American Legion cannot over emphasize the importance of the approval of Medicare subvention for all enrolled Priority Group 7 Medicare-eligible veterans and TRICARE for Life veterans being treated for nonservice connected conditions. This first step is essential in the process of improving health care delivery for this nation's veterans. The American Legion continues to advocate for the approval of Medicare subvention for VHA.

• Enhanced Joint Graduate Medical Education—The American Legion recommends the expansion of joint medical education and training, as well as Joint research and development opportunities would greatly enhance the services of both agencies.

MID-TERM GOALS

• Improved billing and collection—The American Legion recommends either providing enhanced information technology and training to improve VA's billing and collection capabilities or purchasing this service from the private sector.

• Shared patient medical records—The use of technology, such as bridging, would help alleviate current problems of sharing vital information between agencies.

LONG-TERM GOALS

• Contracted TRICARE Services—The American Legion strongly recommends that Congress allow VA to become a primary contractor for DOD health care system. Legislation would be required that would allow VA to act as a primary contractor and be able to compete with the private sector for these contracts. Instead of VA being the subcontractor, it would become the contractor using VHA medical facilities to provide care to TRICARE beneficiaries. This level of cooperation would go a long way in reducing costs for all three Federal agencies DOD, VA and the Centers and would provide consistent, coordinated quality health care for the entire patient population. The American Legion believes this would be the ultimate joint venture that would better coordinate the delivery of quality health care among the Federal agencies without obfuscating their unique missions.

SUMMARY

As a grateful nation, it is a civic responsibility to find the most efficient way to deliver quality and timely health care to this very unique population. The American Legion believes allowing Medicare subvention in VA would eliminate some existing barriers and enable VA and DOD to work closer together in the treatment of TRICARE beneficiaries for nonservice-connected conditions. The American Legion strongly recommends seeking additional joint ventures opportunities between VA, DOD and TRICARE. The American Legion believes joint ventures offer many more opportunities for cost savings through purchasing of pharmaceuticals and medical/surgical supplies and contracting of services. Advances in information technology should be explored to remove Current technology barriers that seem to exist with the exchange of critical information between these health care providers. Finally, best practices of those that have been successful absolutely need to be shared and implemented.

The American Legion believes the success or failure in greater VA and DOD sharing rests in the leadership. As wartime veterans, time and time again we witnessed victory snatched from the jaws of defeat because resourceful and determined leaders found solutions to reach their objectives. Each soldier, sailor, airman, and Marine can cite an impossible task that was accomplished because the Old Man gave the order to get it done. Effective leadership seeks results not excuses. The objective must be tell me how to achieve this goal rather than tell me why it can't work. The American Legion recommends constructive planning in lieu of bureaucratic obstruction be applied in developing joint ventures, resource sharing agreements, and other areas of cooperation.

THE AMERICAN LEGION,
Washington, DC, March 7, 2002

Hon. JOHN MCHUGH, Chairman, Subcommittee on Military Personnel, Committee on Armed Services, Rayburn House Office Building, Washington, DC.

Hon. JERRY MORAN, Chairman, Subcommittee on Health, Committee on Veterans' Affairs, Cannon House Office Building, Washington, DC.

DEAR MR. CHAIRMEN: The American Legion has not received any federal grants or contracts, during this year or in the last two years, from any agency or program relevant to the subject of the March 7 hearing concerning VA–DOD Health Care Sharing.

Sincerely,

STEVE ROBERTSON,
Director, National Legislative Commission.

STEVE A. ROBERTSON, DIRECTOR, NATIONAL LEGISLATIVE COMMISSION, THE AMERICAN LEGION

Steve Robertson was named Director of the National Legislative Division in May 1993.

He began his career with The American Legion in 1988 as Assistant Director of that Division. In 1991 he was promoted to Deputy Director. Prior to his Legion employment, he was a Disabled Veterans Program (DVOP) specialist for Job Service North Dakota.

As a military policeman in the DC Army National Guard, Robertson was activated in January 1991 during the Persian Gulf War and served from February to June in Saudi Arabia. In June 1996, Robertson completed twenty years of military service and will retired at the rank of Captain, USAF, in 2010.

Robertson served twelve years in the U.S. Air Force from 1973 to 1985 as a Security Police Officer in Louisiana, Turkey and North Dakota; a Missile Combat Crew Commander for the Minuteman III ICBM in North Dakota; and as a Flight Commander for the Ground Launched Cruise Missile (GLCM) in Sicily.

A third generation Legionnaire, Robertson's post home is Post 14 in Shreveport, LA. His wife, Vivian Wolf, is an Air Force Lt. Colonel and a member of Post 290 in Stafford, VA. His son, Casey (22) is a member of the Sons and also a Legionnaire. His daughter Jessica (15) is a member of the Junior Auxiliary. His son, Steve (11) is a member of the Sons of The American Legion.

STATEMENT OF HARLEY THOMAS, HEALTH POLICY ANALYST, PARALYZED VETERANS OF AMERICA

Chairman McHugh, Chairman Moran, distinguished members of the subcommittees: On behalf of the members of the Paralyzed Veterans of America (PVA), I am pleased to express our views on potential healthcare sharing between the Departments of Defense (DOD) and Veterans Affairs (VA).

VHA-DOD SHARING

Unrealistic expectations for efficiencies to be achieved by forced integration of the veterans and military health-care systems, threaten to compromise veterans' and DOD beneficiaries' health-care quality and access.

The Paralyzed Veterans Of America is concerned that a potential merger of the two health-care systems, driven primarily by potential cost reduction efforts, could result in potential negative effects on the delivery of services for both beneficiary populations.

PVA, along with many other Veteran Service Organizations (VSOs), support maintaining access to the VA health-care system for all veterans. PVA continues to support the expansion of VHA/DOD sharing agreements, providing they are accomplished in a careful, methodical manner and in the best interest of all populations served. Any potential savings through sharing agreements must be supported by facts and rigorous analysis. Veterans and DOD beneficiaries deserve federal health-care systems that focus on providing first-rate accessible and compassionate service.

VA is the second largest financial supporter of education for medical professionals, and the nation's most extensive training environment for health professionals. Last year alone, VHA's academic affiliates trained more than 85,000 clinicians. These academic affiliations bring first-rate health-care providers to the service of America's veterans. The opportunity to teach attracts the best practitioners from academic medicine along with state-of-the-art medical science to VA. Any coordination or cooperative arrangement made between the VA and DOD systems must not impinge on this specialized mission. In a like manner, the VA's unique research program must be maintained.

VA typically treats a population of older Americans, chronically ill and disabled veterans. As the Nation's leader in such specialized services as blind rehabilitation, spinal cord injury, and mental health, the VA provides the full continuum of health-care to veterans including nursing homes and assisted living in long-term care facilities, to adult daycare and geriatric services. VA prosthetics and research provide services and innovations unmatched in other health care environments. These missions too, are unique in U.S. Medicine and could be threatened if some form of merger were to take place between VA and DOD.

Typically DOD medical facilities treat younger and much healthier patients. DOD facilities have expertise in prenatal, obstetrics, and pediatrics for family members and our active duty military. When DOD beneficiaries acquire conditions typically treated by VA, they are discharged and therefore become eligible for enrollment as VA beneficiaries. This is another example of how the two departments do work together, but also why, in fact they are unique entities.

PVA recognizes there are many areas for VHA/DOD sharing that could provide significant advantages, such as joint purchasing of pharmaceuticals, supplies and equipment. Additionally, there is a need for improved information exchange between the two systems. We do not, however, believe that there are any savings to be gained by forcing patients of one system to use the facilities of the other. While many local arrangements work to improve access and convenience of veterans and DOD beneficiaries, we do not see any need for a national initiative to force increased

cross-system patient care. Beneficiaries of both systems must maintain the full range of health-care choices.

PVA believes that where local situations favor sharing, it should be encouraged, but a national approach to joint health-care services is unlikely to work. VHA and DOD should continue their efforts to improve information exchange and to cut costs by combining their purchasing power in the marketplace.

Enhanced access to high quality health-care services for active servicemembers, veterans, retirees, and family members of active or retired servicemembers as provided by law should be a common goal. Certainly we have a responsibility to see that resources are used wisely to achieve this goal. We understand your goal to increase coordination between VA and DOD health-care systems. However, we do not believe the creation of a hybrid VA/DOD health care system should be one of the recommendations considered by these subcommittees.

This concludes my comments. Thank you for the opportunity to voice our concerns and recommendations. I will be more than happy to answer any questions you may have.

STATEMENT OF JOY J. ILEM, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR OF THE DISABLED AMERICAN VETERANS

Messrs. Chairmen and Members of the Subcommittees:

I am pleased to have the opportunity to present the views of the Disabled American Veterans (DAV) on health care sharing by the Department of Defense (DOD) and the Department of Veterans Affairs (VA). As an organization of more than one million service-connected disabled veterans, the DAV is especially concerned about maintaining an effective VA health care system to meet the unique medical care needs of our Nation's veterans.

The preservation of the integrity of the VA health care system as a separate entity is of utmost importance to the DAV and our members. Our Nation's disabled veterans deserve a system solely dedicated to addressing their health care needs. The quality of VA care is equivalent to, or better than, care in any private or public health care system. VA is well known for it's specialized services-in prosthetics, blind rehabilitation, spinal cord injury care, traumatic brain injury, and post traumatic stress disorder.

We are pleased the Subcommittees are interested in improving coordination between DOD and VA to improve access for beneficiaries of both systems. DAV continues to support the sensible expansion of VA/DOD sharing agreements. We agree that DOD and VA must commit their respective departments to exploring new avenues for significantly improving health resources sharing and to building organizational cultures supportive of health resources sharing. We do not, however, believe that ongoing joint activities demonstrate that sharing should be extended to include a unified budget and management system. Complementary business systems can enhance services to beneficiaries of both systems, but this does not imply integration of the systems. The DAV is adamantly opposed to a merger of the two systems or any other proposal that would erode the integrity of the VA health care system as a separate entity. Veterans deserve a federal Department whose focus is solely upon providing them compassionate service earned through their special sacrifices on behalf of our Nation.

The DAV recognizes the advantages of VA/DOD sharing in the areas of purchasing pharmaceuticals, medical equipment, supplies, and certain support services as well as the need for improved information exchange between the two systems. We do not, however, believe that there are any savings to be gained by forcing patients to choose one system or the other, as recently proposed by the Administration. Nor do we see any need for a national initiative to force increased cross-system patient care. Many local arrangements work to improve access and convenience of veterans and DOD beneficiaries.

The DAV believes that, where local situations favor sharing, it should be encouraged, but a mandatory national approach is likely to work to the detriment of beneficiaries.

The Subcommittee on Health of the House Veterans' Affairs Committee expressed its disappointment with VA and DOD for taking little advantage of opportunities to engage in collaborative joint ventures despite the statutory authority to do so. We agree that both agencies could improve their efforts with respect to sharing in an attempt to use Federal resources most efficiently and effectively. However, we have serious concerns about proposed fully integrated demonstration projects that call for unified staff, budget, and management systems or a new unified hybrid Federal health care facility.

We appreciate the Subcommittees' interest in improving coordination between VA and DOD to improve access to health care for beneficiaries of both systems while achieving efficiencies for the taxpayer. Clearly, to accomplish this goal, we must address and eliminate identified cultural and organizational barriers that have limited VA and DOD facilities from developing or maintaining successful sharing agreements.

Initially, we believe the key to fostering a long-term commitment by the departments to build a more collaborative relationship lies in VA's Under Secretary for Health and DOD's Assistant Secretary for Health Affairs' willingness to make sharing a priority. Secondly, the respective Secretaries of each agency must address, one by one, the underlying fundamental institutional barriers to sharing that each of the systems has identified. We look forward to the recommendations of the VA/DOD Executive and Health Benefits Council, set up to review current policies, regulations, management and billing procedures, and information technology systems. We are also eagerly awaiting the recommendations from the President's Task Force To Improve Health Care Delivery For Our Nation's Veterans. Hopefully, both of these groups will provide valuable insight on currently perceived problems associated with inter-department cooperation and sharing, along with sound proposals to address these problems.

VA and DOD Secretaries should be responsible for monitoring and evaluating each of their respective co-located facilities that have potential for sharing and reward facility directors that successfully negotiate sharing agreements. In regional areas where VA and DOD facilities are co-located, local managers should be strongly encouraged to develop joint working groups to explore possible sharing opportunities.

Recommendations for overcoming cultural and institutional barriers should be submitted to facility directors for consideration. Strategic goals to initiate improved cooperation between the agencies should be developed. A "best practices" model could also be developed to give other facilities with sharing potential the advantage of positive outcomes relating to joint ventures. Both agencies should jointly develop strategic goals to accomplish compatible health information technology systems so that men and women separating from the military experience a seamless transition from active duty soldier to veteran. Oversight from the top down should continue throughout this initiative to ensure that meaningful action is being taken to overcome obstacles.

Clearly, scarce Federal health resources provided through tax dollars should be used effectively and efficiently in order to enhance access to high quality health care services for active servicemembers, veterans, retirees, and family members of active duty or retired servicemembers, as provided by law. Certainly we have a compelling moral duty to honor our pledges to them, and a responsibility to see that resources are used wisely to achieve this goal. We believe one key initiative is Medicare Subvention for VA Priority Group 7 users. Medicare-eligible veterans have been unfairly denied the choice of using their Medicare coverage to pay for VA care. We believe VA participation in this initiative will benefit veterans, taxpayers, and ultimately VA, as long as Medicare subvention dollars are a supplement to an adequate VA appropriation. Funds expected from Medicare are especially important to the financial health of the veterans' health care system.

Medicare-eligible veterans have earned the right to use VA health care services. We strongly urge Congress to pass legislation that permits Priority Group 7 Medicare eligible veterans the option of choosing VA health care and using their Medicare coverage. Citizens purchase Medicare coverage through payroll deductions and should have the right to use those benefits to receive care from the provider of their choice. Medicare subvention would give veterans who currently cannot use their Medicare coverage at VA facilities, but who need specialized care, the option of choosing the VA system and using their Medicare coverage. Additionally, VA believes it can deliver care to Medicare beneficiaries at a discounted rate, which would save money for the Medicare Trust Fund and stretch taxpayer dollars. VA health care costs less, at least 25% less, than private-sector providers billing at Medicare rates. The savings could be realized by reduced cost to patients, through low or no copayments, or passed on to taxpayers by setting subvention rates discounted from standard Centers for Medicare & Medicaid Services (CMS) rates, or by a combination.

The annual potential closure of enrollment for new Priority Group 7 veterans demonstrates that appropriations barely cover Priority Groups 1–6. Medicare Subvention would obviate the need to deny access to Priority Group 7 users. No veteran should be denied access to the veterans' health care system. Veterans, even veterans like those in Priority Group 7, who are not poor, have the right to take advantage of VA health care. However, service-connected and poor veterans should not have

to subsidize care for veterans who have public insurance coverage. Medicare subvention would allow Medicare-eligible Priority Group 7 veterans to become a source of funding rather than a drain on an already over-extended system. Additionally, a large number of Priority Group 7 veterans bring diversity to the case mix and lower average costs. Finally, this group comprises a body of users that could be directed to other Medicare providers outside the VA system in case VA is needed to fulfill its fourth mission as backup to the Department of Defense in time of war or domestic emergency.

While we support Medicare subvention, we would want Congress to ensure that service-connected disabled veterans would not be displaced or forced to wait even longer for necessary health care and that revenue generated from Medicare subvention will not be used to offset Federal appropriations. It does not make any sense to replace appropriated funds with Medicare ftinds. There is no benefit to VA, Medicare, or taxpayers if VA appropriations are offset by Medicare revenues.

The cost of care for this growing population of enrolled Priority Group 7 veterans exceeds medical care collection fund (MCCF) from these patients and their secondary insurers. The DAV, along with the Independent Budget (IB) group, has consistently opposed the offset of MCCF collections. We believe that it is the responsibility of the Federal government to fund the cost of veterans' care; therefore, we do not include any cost projections for MCCF in the IB budget development. VA's historical inability to meets its collection goals has eroded our confidence in VA estimates. We have urged the Administration and Congress to drop this budget gimmick and address the veterans' medical care appropriations in a straightforward manner by providing a realistic budget fully funded by appropriations. We strongly believe monies collected through MCCF should be a supplement to, not a substitute for, appropriations. However, third-party collections from Medicare-eligible Priority Group 7 veterans do not cover the cost of their care, and since appropriations are not sufficient, these funds are redirected away from service-connected and poor veterans to subsidize the Medicare trust fund.

The assumption that subvention dollars should necessarily be offset by VA appropriation reductions is invalid because it is based on the incorrect belief that current appropriations are sufficient to provide services to service-connected, poor, and Priority Group 7 Medicare-eligible veterans. While VHA sets standards for quality and efficiency, veterans' access to health care is constrained. Consistently inadequate appropriations have forced VA to ration care by lengthening waiting times. Last year appropriations were barley sufficient to cover the cost of care for Priority Groups 1–6. Appropriations over the last several years have been insufficient to provide services to service-connected, poor, and Priority Group 7 Medicare eligible-veterans. By VA estimates, there are approximately one million Priority Group 7 users with 50–65 percent of those Medicare eligible. Only 15 percent of Priority Group 7 Medicare-eligible users have billable Medigap insurance, leaving 85 percent where VA receives no insurance reimbursement. The average collections from Medigap insurance for Priority Group 7 Medicare-eligible veterans is estimated at only 12–13 percent of the possible total billable portion. Obviously, VA spends a significant amount of resources on providing health care services for Priority Group 7 Medicare-eligible veterans with little reimbursement. We strongly believe their health care costs should be covered by Medicare funds.

The director of CMS has stated that veterans' care should be covered by VA appropriations and that subvention would represent a double payment by the government. This is a spurious argument; actually, the current situation represents "reverse subvention" with VA appropriations used to pay for care that has already been funded by contributions to the Medicare Trust Fund.

In closing, we ask the Subcommittees to consider the issue of entitlement to VA health care for core Priority groups 1–6. It is difficult to believe that health care for veterans, especially those veterans with combat or service-connected disabilities, is not an entitlement. Veterans' health care is strictly discretionary, and the level of VA health care funding is judged in light of parochial congressional concerns or pork-barrel politics. This is no way to honor America's obligation to the defenders of her freedoms.

Unfortunately, priority health care for our Nation's service-connected disabled veterans has been eroded over the years due to insufficient health care funding. This has resulted in long delays in receiving health care, as well as unfunded mandates, which only heighten the expectations of veterans, but fail to allow VA to perform the mandated services.

The issue of entitlement is important to sharing agreements between VA and DOD because it would ensure that VA has adequate funding to pay for its beneficiaries' care and the necessary staff, supplies, and equipment to provide that care. It would also provide needed stability in VA's planning for the future. With so much

uncertainty in the VA medical care budget due to funding shortfalls, it is questionable if VA would be able to make solid commitments when entering into joint ventures with DOD. Service-connected veterans and veterans for whom VA is mandated by law to provide care, the core Priority groups 1–6 should not have to fight year after year for access to timely health care. Likewise, VISN directors should not be forced to choose between meeting their fiscal responsibilities and providing sick and disabled veterans with the care they need. Each year, because of the uncertainty of the budget, local managers are required to make difficult decisions that impact directly on patient care and the availability and timeliness of services.

The enactment of TRICARE for Life set a precedent for entitlement to health care for military longevity retirees. We believe Congress did the right thing by enacting this legislation. Military retirees dedicated their careers to military service in defense of our nation and are deserving of this benefit. We ask, are veterans who became sick or disabled as a result of military service or other specially identified veterans in the core priority groups any less deserving of a similar health care entitlement?

We strongly believe veterans' medical care funding for the core Priority Groups 1–6 should be an entitlement, rather than subject to annual appropriations. By making VA health care an entitlement, those veterans who choose VA health care would be ensured that annual spending levels would be sufficient to provide for their health care needs.

We thank the Subcommittees for holding this hearing today and providing DAV the opportunity to express our views on VA/DOD health care sharing.

DISCLOSURE OF FEDERAL GRANTS OR CONTRACTS

The Disabled American Veterans (DAV) does not currently receive any money from any federal grant or contract.

During fiscal year (FY) 1995. DAV received $55,252.56 from Court of Veterans Appeals appropriated funds provided to the Legal Service Corporation for services provided by DAV to the Veterans Consortium Pro Bono Program. In FY 1996, DAV received $8,448.12 for services provided to the Consortium. Since June 1996, DAV has provided its services to the Consortium at no cost to the Consortium.

BIOGRAPHICAL INFORMATION, JOY J. ILEM, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Joy J. Ilem, a U.S. Army service-connected disabled veteran, was appointed Assistant National Legislative Director of the million-member-plus Disabled American Veterans (DAV) on August 24, 2000.

Ms. Ilem is employed at DAV National Service and Legislative Headquarters in Washington, D.C. As a member of the DAV's legislative team, she works to promote and defend reasonable and responsible legislation to assist disabled veterans and their families.

Ms. Ilem began her DAV career as a member of Class III at National Service Officer Training Academy in Denver. Following graduation from the academy in 1996, she was assigned as a NSO Trainee at the National Service Office in Phoenix, Ariz. In 1997, she was assigned as a National Appeals Officer with the DAV staff at the Board of Veterans Appeals in Washington, D.C., where she served until her appointment, as Associate National Legislative Director in April 1999.

A native of Shakopee, Minn., Ms. Ilem was raised in the greater Minneapolis area, and is a 1977 graduate of Totino Grace High School in Fridley, Minn. She earned her bachelor's degree from the University of Arizona at Tucson in 1994, where she majored in archaeology, with a minor in religious studies.

Ms. Ilem enlisted in the U.S. Army in 1982. Following basic training at Ft. Jackson, S.C., and advanced medical training at Ft. Sam Houston, Texas, she was assigned as a combat medic to the 67th Evacuation Hospital in Wurzburg, Germany, where she underwent additional certification as an emergency medical technician (EMT). Ms. Ilem's military duties included emergency room assignments and noncommissioned officer in charge (NCOIC) of recovery room operations. She was honorably discharged from the Army in 1985.

A life member of DAV Chapter 1, Washington, D.C., Ms. Ilem resides in Washington, D.C.

STATEMENT OF DENNIS CULLINAN, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. Chairmen and Members of the Subcommittees:

On behalf of the 2.7 million members of the Veterans of Foreign Wars of the United States (VFW) and its Ladies Auxiliary, I would like to thank you for the opportunity to discuss ways in which DOD and VA can promote greater sharing of federal health care resources.

This important concept was authorized in 1982 by the enactment of PL 97–174, the Veterans' Administration and Department of Defense Health Resources Sharing and Emergency Operations Act. The codification of this Act in 38 U.S.C. §8111 and 10 U.S.C. § 1104 states that "the Secretary [VA] and the Secretary of the Army, the Secretary of the Air Force, and the Secretary of the Navy may enter into agreements and contracts for the mutual use or exchange of use of hospital and domiciliary facilities, and such supplies, equipment, material, and other resources as may be needed to operate such facilities . . ."

In addition, Title 38 U.S.C. §8110 mandates VA to serve as the principal backup to DOD in the event of war or national emergency by "maintain[ing] a contingency capacity" within their medical facilities. The VFW recently testified before Congress regarding this specific section of the law. I have taken the liberty to attach a copy of that testimony for your information.

Before we address the numerous opportunities for sharing between DOD and VA, we believe it important to note that they are two, separate and distinct entities with different missions: One, to fight and win the nation's wars; and the other, to care for those who bear the scars from those wars. VA conducts its health care mission as a direct care provider to honorably discharged veterans through the Veterans Health Administration (VHA), while DOD conducts its health care mission as a direct care provider and insurance purchaser (TRICARE) for members of the Armed Forces, retirees, and their dependents through the Military Health System (MHS). As such, they both possess cultural and institutional barriers that must be broken down, or at the very least mitigated, in order to create a healthcare partnership. We know from experience that this is easier said than done.

Therefore, we were not surprised to find that this partnership has been slow to develop. This unhurried pace is evidenced by the fact that both systems have been authorized to share health care resources for nearly twenty years and the most recent testimony by the Congressional oversight staff before this task force stated that there were 400 active agreements at 160 facilities and most alarming is only 30 are actually working. Congressional testimony concerning resource sharing delivered by DOD and VA in May 2000, however, stated that there were over 800 sharing agreements in place. As a veteran's service organization, we find ourselves deeply troubled and perplexed over this discrepancy in data. The question arises, are these agreements that are in place being enacted and what type of accountability or incentive is there to ensure that they are?

We believe that increased projected savings and better services for beneficiaries from sharing agreements can only be realized if there is a total commitment from the highest levels of each Department. The respective secretaries must shine a spotlight, so to speak, on DOD/VA health care resource sharing. Their delegates must understand that they have the authority to identify and enact mutually beneficial agreements and in fact, are expected to act. Failure to act on identifiable and beneficial agreements should be met with swift Departmental and Congressional action.

Further troubling to the VFW is the finding by Congressional Commission on Servicemembers and Veterans Transition Assistance (Principi Commission) that stated both systems share only $62 million of a combined $32 billion plus healthcare budget while "both healthcare systems face the challenge of adapting to changing health care practices, an evolving patient population, infrastructure built for another era, and increasing healthcare costs in a time of severe budget pressure." Government Accounting Office (GAO) studies and Congressional hearings have further highlighted and suggested the need to restructure the two systems in order to promote and maximize greater sharing of health care resources and to potentially reduce costs due to duplication and/or under use of those resources. We concur with these assessments in that there is need for improved coordination between both systems. We, however, question what constitutes the standard of success for sharing agreements: Mere cost savings or enhanced beneficiary access and quality care?

The VFW cannot emphasize enough our conviction that any sharing agreement between DOD and VA conform to 38 U.S.C. §8111(c)(1) in that it not "adversely affect the range of services, the quality of care, or the established priorities for care provided by either agency." Simply put, we will support only that that does no harm to the beneficiary no matter the cost savings that may be generated. Further, any

savings realized as result of a sharing agreement should be immediately reinvested into their respective health care systems without offset from congressional appropriation. This is vital in that there would be no need to emphasize sharing or restructuring if both systems were flush with adequate appropriations every fiscal year.

For all their differences, we believe there are a number of areas where DOD and VA can work together to improve cost sharing as well as the range of services and the quality of care provided to our nation's Armed Forces, military retirees and veterans. In fact, they already are in certain areas. The VFW supports expanding and enforcing these existing types of agreements while encouraging both agencies to continue to identify new sharing agreements extending to every military branch and ranging from proven models such as: shared staffing; buying or selling services; joint ventures such as the Alaska VA Healthcare system which boasts a VA/DOD hospital shared with the 3rd Medical Group, Elmendorf Air Force Base; joint purchasing of pharmaceuticals and medical/surgical supplies; education and training to include Graduate Medical Education; consolidated procurement; joint research groups such as the Persian Gulf Veterans Health Coordinating Board which has evolved into the Military and Veterans Health Coordinating Board; and advanced technology such as the Government Computer-based Patient Record project.

In addition, we are aware both departments are considering the process and means of realigning their assets to enhance the way they do business; VA with its Capital Asset Realignment for Enhanced Services (CARES) and DOD has been authorized a future round of Base Realignment and Closure (BRAC). The VFW believes that these programs provide an important and timely venue for DOD and VA to consider new means of sharing agreements. This is especially relevant in the area of joint ventures. It is imperative that interagency communications exist at all levels and phases of the restructuring processes and careful attention should be paid to changes occurring within each department as a result.

We also note with interest that both the National Defense Authorization Act (NDAA) and the VA–HUD Appropriation Act Conference Reports for fiscal year 2002 contain prescriptive language in the area of VA–DOD health care sharing. While the NDAA extends sharing agreements in graduate medical education and separation physicals, VA–HUD calls for DOD and VA to find "no less than three demonstration sites where DOD and VA will fully integrate operations, pharmacy services, billing and records, and treatment." We respect and support Congress' actions to get things moving faster, however, forced integration for cost reasons should not be thrust upon the two agencies to the detriment of beneficiary care and access.

As this task force considers new and innovative ways to improve health care delivery for our nation's veterans we would recommend you focus your attention on what we believe could provide a viable and significant alternative funding source (other than appropriations) for VA-Medicare Subvention. The subvention concept would allow VA to collect and retain Medicare dollars while at the same time providing Medicare-eligible veterans with the option of having VA provide for their non-service connected health care needs.

It is important to point out that many Medicare-eligible veterans, principally among the military retirees, would prefer VA health care to care provided by the private sector. Unfortunately, current law prohibits Medicare from reimbursing VA for the medical services it provides to eligible veterans. This, in spite of the fact that these very same veterans may go to the private sector providers and take their earned Medicare dollars with them. This situation deprives veterans of the VA health care they earned and desire while denying the system desperately needed additional funding.

DOD recently completed a three-year pilot program on Medicare subvention and GAO found that "enrollees in [the pilot program] said they were better able to get care when they needed it. They also reported better access to doctors in general as well as care at military treatment facilities. Enrollees generally were more satisfied with their care than before the demonstration." We note that the cost for this program was higher for DOD. VA, on the other hand, already possesses and can provide health care services at lower cost than DOD thereby providing expanded access to more veterans and cost savings to the Medicare Trust Fund.

The VFW has made Medicare subvention one of its top legislative priorities. This past August, our National Convention approved VFW National Resolution #622 calling for a change in law that would authorize VA to collect and retain all Medicare dollars. I have attached a copy of this resolution for your use.

Once again, we are thankful for the opportunity to participate in today's important hearing and we hope we were able to contribute sensible recommendations to you as you seek to make sound policy for the next generation of our nation's armed forces, military retirees and veterans. This concludes my testimony and I would be

pleased to answer any questions you or the members of this subcommittee may have at this time.

DENNIS M. CULLINAN, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Dennis Cullinan is a native of Buffalo, New York, and was promoted to the position of Director of the National Legislative Service of the VFW Washington Office.

Prior to being honorably discharged from the U.S. Navy in 1970, Dennis served as an electronic technician aboard the USS *Intrepid* (CVS–11) and completed three tours of duty in Vietnamese waters. After his discharge, Dennis studied abroad with two years at the Catholic University of Nijmegen, the Netherlands. He later completed his undergraduate education at State University of New York in Buffalo where he also received his M.A. degree in English.

After several years of teaching freshmen composition and creative writing, Dennis became a member of the VFW Washington Office staff in its National Veterans Service department. He later advanced to positions in the VFW's National Legislative Service department and became its Director in August, 1997.

Dennis enjoys an active involvement in crew as a member of the Occoquan Boat Club of Northern Virginia. He and his family reside in Lakeridge, Virginia, where he is a member of VFW Post No. 7916.

RESOLUTION NO. 622—VA MEDICARE SUBVENTION

Whereas, the VA health care system must provide all veterans access to a full continuum of care; and

Whereas, the Department of Veterans Affairs has suffered from years of chronic under-funding, limiting its ability to properly care for its current workload; and

Whereas, it is now absolutely essential that VA be authorized to capture and retain federal dollars in addition to its annual appropriation so as to revamp and revitalize its health care system; and

Whereas, a large number of VA's potential patients are Medicare eligible; now, therefore

Be it resolved, by the Veterans of Foreign Wars of the United States, that we support the swift enactment of legislation authorizing VA to collect and retain all Medicare dollars.

Adopted by the 102nd National Convention of the Veterans of Foreign Wars of the United States held in Milwaukee, Wisconsin, August 18–24, 2001.

STATEMENT OF THE VIETNAM VETERANS OF AMERICA, SUBMITTED BY RICHARD WEIDMAN, DIRECTOR, GOVERNMENT RELATIONS, WITH PATRICK G. EDDINGTON, ASSOCIATE DIRECTOR OF GOVERNMENT RELATIONS

Chairman McHugh, Chairman Moran, and other distinguished members of the Veterans Affairs and Armed Services committees, Vietnam Veterans of America (VVA) is grateful for this opportunity to provide testimony on the issue of DOD–VA health care sharing.

VVA believes that any discussion of this subject must begin by facing one central fact: the purposes of the two medical systems (and therefore their missions, corporate culture, and mind-set) are very different, and that therefore the needs of each system must be tailored to the needs of the specific population it serves. Ignoring this reality guarantees that any legislative initiative designed to improve coordination will ultimately fail to meet its objective.

VVA believes that any attempts at DOD–VA sharing must be focused primarily on:

- Changing the DOD and VA healthcare system's corporate culture from one of "generic health care for veterans and service members" to one of a "military and veterans unique health care."
- Establishing a medical education system that emphasizes the unique nature and hazards associated with military service, and the communication of those hazards to all medical providers within both medical systems through mandatory continuing and graduate education courses.
- Creating a common, life-long military medical history for each service member that can be seamlessly transferred to and updated by the Veterans Health Administration when the service member becomes a veteran.

• Reversing years of declining appropriations, and therefore ever-diminished organizational capacity, by providing adequate resources for both systems to deal with the existing and future population of veterans.

VVA believes that many changes need to be made before either the Pentagon or the VA addresses the special needs of veterans or the special needs of those still on active duty who may have been exposed to certain conditions unique to military service. Let us share with you our philosophical approach to veterans and military health care.

VHA MUST DELIVER QUALITY VETERANS HEALTH CARE

VVA believes general health care will overlook many maladies and conditions that are particular to the military and veteran populations, and therefore military and veterans' health care is different than general health care. The average civilian will never be exposed to the kinds of toxic hazards and battle-related stressors that veterans have endured.

Accordingly, any medical system designed to deal with the unique medical and psycho-social problems affecting military members or veterans must put those wartime or service-related experiences and exposures at the heart of all medical education, diagnostic, and treatment programs for veterans.

NEED FOR TAKING A COMPLETE MILITARY SERVICE HISTORY

To properly diagnose a veteran, DOD and VA must properly assess and deal with the events, conditions, and experiences that may have occurred to the individual while in military service. VVA strongly believes that this must be the first priority of both the Pentagon medical system and the VA in order to provide quality veterans health care. One must first start with a complete and intelligently gathered military history, that would include the questions "what branch did you serve in, when did you serve, where did you serve, what was your MOS (i.e., your military job), and what actually happened to you in military service." The average American taxpayer would be amazed to learn that DOD and VA clinicians do not, as a matter of routine operating practice, ask these basic questions. The Institute of Medicine observed as much in its 2000 report Protecting Those Who Serve: Strategies to Protect the Health of Deployed U.S. Forces.

Indeed, if one examines the post-deployment health instruments currently being used by DODs Deployment Health Clinic Center at Walter Reed Army Medical Center, you will find that said instruments do not capture the kinds of data that VVA and IOM believe are essential to properly track environmental or other hazards deployed personnel may encounter.

Presently the DHCC post-deployment health questionnaire contains no questions about a service member's potential exposures to pesticides, chemical or biological agents, or other similar exposures—a completely inexcusable omission in light of the Vietnam and Gulf War experiences. By not getting it right up front, DOD is ensuring that the decades-long problem of incomplete medical and environmental exposure documentation will continue to compromise the ability of veterans to receive accurate diagnoses and treatment.

Once one has the answers to the above questions about when and where, etc. about a veteran's service, then additional knowledge of various military campaigns and cruises must be available online (preferably automatically) to the physician, so that the proper tests can be administered to properly diagnose diseases and conditions that the veteran may have as a result of military service.

As an example, a veteran who served on the ground in Vietnam should automatically be tested for tuberculosis, hepatitis C, dioxin levels and possible herbicide related illnesses, possible post traumatic stress syndrome or other neuropsychiatric wounds of war, and the tropical diseases and parasites that can remain in the body for decades before manifesting, such as strongyloides, melioidosis (Whitmore disease), malaria, and the like. There may well be additional possible exposures and conditions for which one should test veterans who were deployed to Vietnam, other than the few illustrations noted above.

Currently no VHA facility we know of regularly does testing for all of the above. (We would note that all facilities are currently required to offer testing for hepatitis C to all Vietnam era veterans, although it often does not happen.) Most VHA physicians have never even heard of melioidosis or strongyloides, although both are endemic in Southeast Asia, particularly Vietnam. So is tuberculosis and hepatitis C. Vietnam has one of the highest hepatitis rates (of all types) in the world. Obviously veterans who were deployed in Korea or other cold climates would have a different set of exposures, as would those deployed in Southwest Asia, Bosnia, or those currently serving in Central Asia. These veterans today may well be carrying these dis-

eases today, but do not know it because no one has ever known to test for these conditions and the individual veteran had no knowledge either.

We have provided you with the Military Service History cards (See attachment I) that each clinician at VHA is supposed to use. Dr. David Stevens (and his colleagues in VHA Academic Affairs) designed these cards for the young residents and interns who are constantly rotating through our hospitals and clinics. These young physicians in training generally know very little if anything about veterans, much less the specific conditions or maladies that veterans may have as a result of military service many years ago. Dr. Stevens and his colleagues also found that permanent staff who should have known these things, understood veterans, and asked the right questions as a matter of course often did not.

One can go to www.va.gov/oaa for more information about what each of the questions on the card mean, although there is a great deal to add to the Office of Academic Affairs (OAA) site's database (or have it linked with other sites) in order to make it useful. A much larger problem is that the overwhelming majority of clinicians at VHA have never even seen this card, much less use it daily as an aid in diagnosis on a daily basis. The use of electronic clinical reminders has helped some in this regard, but only where they are regularly employed.

It is axiomatic that if one does not ask the right questions, then one will not get the right answers. If you do not get the right answers, then the clinician will render an incomplete or a wrong diagnosis. An incomplete diagnosis will by definition ensure improper patient treatment, and he or she will not really get well. The VHA will send that person along with the wrong course of treatment, and we will then continue to churn veterans back and forth through the system. That is in large measure the case today. If it is worth providing health care to our nation's veterans (and I hope we can all emphatically agree that it is), then it is worth doing it right the first time.

The VHA now has a project known as the Veterans Health Initiative (VHI), which would initiate proficiency tests in veterans' health for clinicians. Those that pass every three years will be rewarded with additional merit pay. In addition, the VHI is working on a computerized format for a complete military history that would contain not only clinical reminders for the physician, but mandatory indicators for certain medical tests based on the military history. These are excellent steps, but they must be institutionalized in both VA and DOD if we are to make genuine progress in this area.

A VITAL NEED FOR FUNDS

Today, the VA medical system is indisputably far from what it was in the decade following World War II. At that time, the very best and most advanced medical care in the world was available to our veterans. As we and other veteran service organizations have testified previously, the VA medical system's capacity to treat veterans has declined dramatically over the past decade. The VHA, as all of us in this room know, is being starved to death for funds to operate even at its reduced capacity.

Like the human body does when starved for food, institutions starved for resources are distorted in strange ways, and the weakest parts of the system suffer the most. So it is with the Veterans Health Administration's health care system, after five years of severe and acute under funding, on top of chronic under funding in the past 35 years. The VHA distortions have manifested themselves in the slashing of the specialized services, such as spinal cord injury, blind and visual services, serious and chronic mental illness (those least able to fend for themselves), and prosthetics. All are operating below the legally mandated level of capacity for specialized medical services, which is set by law at the FY96 level. Yet these services are really at the heart of the VA's mission.

Even beyond these distortions due to lack of resources, however, it has become apparent that the VA overall, and VHA in particular, needs to do a much better job of meeting the real mission. To do so, we do need significant additional resources. We also need a sharper focus, additional tools to hold managers and clinical chiefs truly accountable, and a dramatic change in the corporate culture of the VA overall. VHA must provide "Veterans Health Care" that is truly comparable with the best health care of any sort that is available in America. We need a system that is capable of being even better for veterans than a private hospital, because it would understand the special needs of the Americans who have prepaid the price for using it.

Much has been made of the fact that the appropriation for the Department of Defense (DOD) has significantly declined as a percentage of the Gross Domestic Product (GDP). Whatever the right number is for DOD, it is a good reference point, along

with medical costs increase rates to understand what has happened to the national treasure that is the VA health care system.

The rate of increase of the VHA budget has lagged far behind in comparison to DOD and even the minimum of 8% increase in medical costs (the civilian sector has averaged more than 10% in annual medical costs increases over last three years). You can find out what a family, an organization, or a nation really values by where it puts its money. If we really value our current veterans as much as the President and our elected leadership says we do, then we have to restore lost organizational capacity, keep pace with medical inflation, and seek better accountability from VHA managers. To do anything less is breaking faith with veterans and with the oft-repeated pledge of health care second to none for veterans.

HOLISTIC MODEL OF VETERANS HEALTHCARE

The difficulty with health care at the VHA, as in much of American medicine, is that it focuses only on the immediate presentation, instead of doing a complete workup of what is needed in order to truly make this veteran well again. Taking a military history is key. Such a work up must factor in the long term heath effects of all the exposures that occurred in the military, from hostile fire to diseases to exposure to nuclear, chemical, or biological weapons or agents in any form, herbicides and other toxins, as well as psychiatric health. One must assess the whole veterans as one whole human being. Treating the veteran as an episode has gotten us in to the mode of "churning" veterans through the system for acute medical episodes that could have been prevented.

The end goal of this holistic approach to veterans' health care must be helping working-age veterans get to the point where they can obtain and sustain meaningful work at a living wage. VVA suggests that the goal of all of the programs and services for veterans should be helping each veteran get and keep meaningful work. Helping veterans realize their potential in the marketplace should be the primary goal of all of the VA's programs. Most of the focus of VHA programs, particularly for veterans of a working age should be to work with the other programs of VA toward this end. The primary care teams have been a significant step in the right direction, but much more needs to be done.

CORPORATE CULTURE AND MINDSET

The mindset of all of the managers and key leaders at DOD and VA must be directed at creating an atmosphere where it is the norm to go the extra step to assist the servicemember or veteran, and keeping all activities truly focused on the needs of the servicemember or veteran and not the bureaucracy. It has always impressed all of us at VVA as to just how many fine and dedicated people stay at the VA and just keep struggling to provide the very best veterans health care possible, despite the obstacles and lack of rewards that all too often is the repayment for their labors. We must achieve a corporate culture that rewards public servants for initiatives that better meet the needs of servicemembers and veterans, as opposed to being punished for showing initiative, as is all too often the case today.

ACCOUNTABILITY

The issue of greater accountability is one that VVA has focused on for years, especially the past four years. It now appears that VA is moving toward a financial tracking system where they can actually tell where the money is going and what it is actually being used for at the Network and local levels. Apparently a comparable Management Information (MIS) system that is "real time" is in the works and should be on line by 2004 as well. These are welcome and positive steps that VVA applauds.

VVA also believes that we must go further to make permanent employees in the senior grades (i.e., Grades 14, 15, 16, and SES) more accountable to duly appointed leadership, and to taking the will of Congress as the law, and not just cute ideas suggested to them. This would help senior leadership and all those who wish to do the very best job possible for our nation's veterans. Tying senior executive's bonuses to demonstrable performance improvements is key in this regard, and we urge both committees to examine such mechanisms carefully.

LEADERSHIP IS ESSENTIAL

Whether or not the focus, the accountability tools, and the corporate culture can be changed to the point that VHA is doing its job well enough that real cooperation with the military hospitals becomes possible.

Beyond the contracting for the sharing of some facilities and equipment that is on a somewhat larger scale than what currently exists, it is simply not feasible to combine a VHA in critical flux with an also dramatically downsized military medical system without diminishing both systems. Adding 2+2 in this case equals three in terms of quality healthcare that is designed and capable of meeting the needs of those who would be projected to use it.

If the goal of this possible combining is to "save money," then it is ill fated from the start. What the question really should be is how can we achieve the most cost effective as well as cost efficient veterans healthcare system, as well as achieving the most cost efficient and cost effective military medical system in the continental United States. That is what our service members and their families deserve. That is also what our veterans deserve.

What is possible and desirable is more joint planning for how to meet the fourth mission, and an honest assessment of how much money it is going to take for these two systems to prepare for what the President has characterized as a long and dirty war until we achieve our objective. VVA hopes that we are wrong, but we believe that it is extremely likely we will suffer significant casualties overseas, as well as here at home, at some point in the next two to three years. If such a mass casualty event occurs, the current organizational capacity of the VHA and of reduced state of military hospitals is such that we are likely to be overwhelmed. We urge both the Armed Services and Veterans Affairs committees of this House to prevent that potential tragedy by providing adequate resources and management accountability tools for both systems.

Chairman McHugh, Chairman Moran, thank you again for providing us with this opportunity to share our views on this most important and timely topic.

ATTACHMENT I: MILITARY SERVICE HISTORY CARD

MILITARY SERVICE HISTORY

- Tell me about your military experience.
- What did you do?
- When and where did you serve?
- How has it affected you?

If your patient answers "Yes" to any of the following questions, ask: "Can you tell me more about that?"

- Were you a prisoner of war?
- Did you see combat, enemy fire, or casualties?
- Were you wounded or hospitalized?
- Did you participate in any experimental projects?
- Do you have a claim pending or do you have a service-connected condition?

ISSUES OF CONCERN

It is recommended that all veterans be asked these questions.

Hepatitis C Virus (HCV) Infection

- Are you a Vietnam-era veteran?
- Did you have a blood transfusion before 1992?
- Have you ever injected drugs such as heroin or cocaine?

Pain as the Fifth Vital Sign

- Are you having pain now?
- On a scale of 0–10, how would you rate your pain?

Homelessness

- Where do you live?
- Who lives with you?
- What have you done for a living?

Sexual Harassment and Trauma

- Have you ever experienced physical, emotional, or sexual harassment or trauma?
- Is this causing you problems now?
- Do you want a referral?

PTSD (Post Traumatic Stress Disorder)

If you suspect PTSD, refer to web site for more info. http://www.va.gov/oaa/.

VIETNAM VETERANS OF AMERICA, FUNDING STATEMENT

Vietnam Veterans of America (VVA) is a national non-profit veterans membership organization registered as a 501(c)(19) with the Internal Revenue Service. VVA is also appropriately registered with the Secretary of the Senate and the Clerk of the House of Representatives in compliance with the Lobbying Disclosure Act of 1995.

VVA is not currently in receipt of any federal grant or contract, other than the routine allocation of office space and associated resources in VA Regional Offices for outreach and direct services through its Veterans Benefits Program (Service Representatives). This is also true of the previous two fiscal years.

For Further Information, Contact: Director of Government Relations, Vietnam Veterans of America, (301) 585–4000, extension 127.

RICHARD WEIDMAN, DIRECTOR, GOVERNMENT RELATIONS

Richard Weidman serves as Director of Government Relations on the National Staff of Vietnam Veterans of America (VVA). He served as a medic during the Vietnam War, including service with Company C, 23rd Med, Americal Division, located in I Corps of Vietnam, in 1969.

Mr. Weidman was a volunteer with VVA in 1978 and then part of the staff of VVA from 1979 to 1987, serving variously as Membership Service Director, Agency Liaison, and Director of Government Relations. He left VVA to serve in the Administration of Governor Mario M. Cuomo (NY) as Director of Veterans Employment & Training for the New York State Department of Labor.

He has served as Consultant on Legislative Affairs to the National Coalition for Homeless Veterans, and served at various times on the VA Readjustment Advisory Committee, the Secretary of Labor's Advisory Committee on Veterans Employment & Training, the President's Committee on Employment of Persons with Disabilities, the Advisory Committee on veterans' entrepreneurship of the Small Business Administration, and numerous other advocacy posts in veteran affairs.

Mr. Weidman was an instructor and administrator at Johnson State College (Vermont) in the 1970s, where he was also active in community and veteran affairs. He attended Colgate University, (B.A.–1967), and did graduate study at the University of Vermont.

He is married and has four children.

PATRICK G. EDDINGTON, ASSOCIATE DIRECTOR, GOVERNMENT RELATIONS

Patrick G. Eddington was an award-winning military analyst at the CIA's National Photographic Interpretation Center for almost nine years. He received numerous accolades for his analytical work, including letters of commendation from the Joint Special Operations Command, the Joint Warfare Analysis Center and the CIA's Office of Military Affairs.

During his tenure at CIA, Eddington worked a wide range of intelligence issues. His analytical assignments included monitoring the break-up of the former Soviet Union; providing military assessments to policy makers on Iraqi and Iranian conventional forces; and coordinating the CIA's military targeting support to NATO during Operation Deliberate Force in Bosnia in 1995.

Eddington received his undergraduate degree in International Affairs from Southwest Missouri State University in 1985 and master's degree in National Security Studies from Georgetown University in 1992. Eddington spent eleven years in the U.S. Army Reserve and the National Guard in both enlisted and commissioned service.

Currently, Eddington serves as Associate Director of Government Relations for Vietnam Veterans of America. His opinion pieces have appeared in a number of publications, including the Washington Post, Los Angeles Times, Washington Times, Fort Worth Star-Telegram, and the Army Times, among others. Eddington is a frequent commentator on national security issues for the Fox News Channel, MSNBC, SKYNews, CNN, and other domestic and international television networks. His first book, Gassed in the Gutf, is a detailed examination of the Gulf War Syndrome controversy and its impact on Desert Storm veterans. Eddington is a member of the Authors Guild and Amnesty International. He and his wife Robin live in Alexandria, Virginia.

STATEMENT OF CMSGT (RET.) JAMES E. LOKOVIC, DEPUTY EXECUTIVE DIRECTOR AND DIRECTOR, MILITARY AND GOVERNMENT RELATIONS, AIR FORCE SERGEANTS ASSOCIATION

On behalf of the 135,000 members of the Air Force Sergeants Association, I appreciate this opportunity to make a few observations that we believe are germane to the issues you are presently considering. AFSA represents current and past enlisted members of the Air Force, Air National Guard, and Air Force Reserve and their family members and survivors. Additionally, AFSA is a federally chartered Veterans Service Organization with a considerable network of volunteers who provide voluntary service at veterans' health establishments.

DOD–VA HEALTH CARE SYSTEM SHARING ARRANGEMENTS

AFSA has been open to DOD–VA resource sharing only if the care provided in both systems is equal in terms of services, quality, and accessibility, and the care of neither system and its beneficiaries is jeopardized. Clearly, the two systems address the health care needs of two very different groups of servicemembers, and the budgetary considerations of each parallels its specific mission. The two systems should not be merged.

One example of a sharing arrangement that would benefit both the VA and DOD would be to increase utilization of VA medical centers as TRICARE network providers. Current usage is minimal for several reasons including lack of integrated Information Management capabilities and multiple claims handling systems. Comments from our members relative to quality of service and accessibility suggest that the VA system would benefit to a greater extent than would DOD through sharing arrangements. For example, in most instances, the VA cannot meet TRICARE Prime access standards, i.e. routine appointments within 7 days; specialty appointments within 30 days. By enforcing DOD's standards on VA medical centers, the VA and the service provided to its beneficiaries would improve.

It should be noted that there are instances where sharing arrangements appear to have been successful. The military/veterans facility at Nellis AFB is one notable example, and our members in the Las Vegas-area who use this facility are satisfied with the care they receive. We urge continuation of sharing arrangements within existing legislation—at the discretion of those who are caretakers of the budgeting and quality of each system. Mandating such arrangements with the ultimate forced merger/combination of the two systems, however limited, would undermine the mission of each and potentially compromise the health care provided in one system or the other. Again, AFSA supports VA–DOD) sharing arrangements only in those instances where (1) the needs of the population in each particular area support such arrangements; (2) the quality of care, range of services, and accessibility for beneficiaries are not degraded; and (3) those beneficiaries traditionally served by the VA system or the DOD system receive top-quality care, at no additional cost, as promised in return for putting their lives on the line for their nation.

FORCED DOD–VA HEALTH CARE CHOICE

As you are well aware, as part of its FY 2002 Budget plan, the Bush Administration sought consideration of a new concept: forcing military retirees to choose between the DOD and VA health care systems for their personal health care. Current practice is that military retirees may obtain care from the DOD system; because they are also veterans they may obtain care from the VA system. The Administration initiative focused on the prospective improved manageability of budgetary concerns that would result if retired veterans had to exclusively choose their health care from one source or the other. The members of this association do not support this forced choice, feeling that they have earned the right to whichever system best meets their needs at a particular time. Additionally, the two systems are not equal in terms of quality and range of services available.

Accordingly, our members were very pleased with the language in the FY 2002 National Defense Authorization Act, PL 107–107, Section 731, that stated: "The Secretary of Defense may not take any action that would require, or have the effect of requiring, a member or former member of the armed forces who is entitled to retired or retainer pay to enroll to receive health care from the Federal Government only through the Department of Defense." While this prohibition is directed to DOD, it is clear that Congress accepts the premise that military retirees are veterans and should be able to avail themselves of care in either the DOD or VA health care systems, and we support this congressional.

What were the reasons that retired military members responded so clearly and forcefully against the forced (DOD or VA) health care choice? From the communications we received from our members, the following issues repeatedly were cited.

- Military retirees have earned the right to care in both systems.
- It is unfair to force a choice of care between two systems that differ considerably in quality of care, availability of resources, and services covered.
- Many appreciate having the choice between the two systems, each of which at one time or another may serve their medical needs.

"I would much prefer to have the choice of health care because it offers me health care under a variety of circumstances. When I had a series of problems associated with my heart, the VA hospital was full and could not help me, so I had to use the DOD program (but it was expensive). When I moved to a new location I could not get VA support immediately but was able to receive support at a military treatment facility. [In contrast] when I lived in a remote area the only support I had was through the VA. So, having the choice is very important for me." SMSgt (Ret.) Charles F. Grisham, Utah.

Other correspondence we have received indicates that sometimes a local DOD facility (due to local policy—no doubt driven by budgeting) may not provide a certain service to a retiree whereas a VA facility might. What a mistake it would be to force a retiree to choose one or the other!

This type of correspondence is typical of that which we receive relating to the forced DOD-VA choice issue. Most military retirees already use one system or the other fairly exclusively—but forcing a choice of one system or the other might hurt (physically and financially) those who devoted their prime years to serving their nation.

It is clear from the communication of our members, the instances of crossover between the systems are usually caused by inadequacies in the systems themselves. Military retirees use both systems only when either system cannot satisfy their medical needs—usually due to unequal health care services provided and unequal accessibility of care. The bottom line is that retired military members don't cross between the two systems just to do it; they are driven to do it because of a deficiency in either or both systems. Because of the reasons above, AFSA opposes a forced choice for military retirees between the VA and DOD health care systems, either by law, or through a "de facto mandate" created by establishing prohibitive usage fees, deductibles, or co-payments.

Thank you again for this opportunity to express the views of our members on these important issues. It is important that those who are caretakers of the taxpayers' money budget wisely. However, AFSA contends that it is of greater importance that a grateful nation provide quality health care and top-notch benefits in exchange for the devotion, sacrifice, and service of military members. If we can be of further service to this task force, please do not hesitate to contact us.

STATEMENT OF THE NATIONAL MILITARY FAMILY ASSOCIATION

The National Military Family Association (NMFA) is the only national organization whose sole focus is the military family and whose goal is to influence the development and implementation of policies which will improve the lives of those family members. Its mission is to serve the families of the Seven Uniformed Services through education, information and advocacy.

Founded in 1969 as the Military Wives Association, NMFA is a non-profit 501(c)(3) primarily volunteer organization. NMFA today represents the interests of family members and the active duty, reserve components and retired personnel of the seven uniformed services: Army, Navy, Air Force, Marine Corps, Coast Guard, Public Health Service and the National Oceanic and Atmospheric Administration.

NMFA Representatives in military communities worldwide provide a direct link between military families and NMFA staff in the nation's capital. Representatives are the "eyes and ears" of NMFA, bringing shared local concerns to national attention.

NMFA receives no federal grants and has no federal contracts.

NMFA has been the recipient of the following awards:

Defense Commissary Agency Award for Outstanding Support as Customer Advocates (1993)

Department of the Army Commander Award for Public Service (1988)

Association of the United States Army Citation for Exceptional Service in Support of National Defense (1988)

Military Impacted Schools Association "Champion for Children" award (1998)

Various members of NMFA's staff have also received personal awards for their support of military families.

NMFA's web site is located at http://www.nmfa.org.

The National Military Family Association (NMFA) thanks you, the Members of Personnel Subcommittee of the House Armed Services Committee and the Health Subcommittee House Veterans' Affairs Committee, for holding this hearing to discuss potential collaborative efforts between DOD and the Department of Veterans Affairs (VA). As the only military-related association whose sole focus is the military family, NMFA represents Uniformed Services members and families of the active and reserve components, retirees and their families, and survivors. This is a diverse population in terms of age, gender, and health care needs. Because of this diversity, NMFA is grateful for this opportunity to discuss with the Subcommittees the health care needs of the total DOD beneficiary population as they relate to potential collaborative efforts by the two Departments. We believe collaboration must be beneficiary-focused and driven by a shared vision in both Departments of improving health care delivery to all beneficiaries. This vision must accommodate critical differences in the Departments' cultures, missions, beneficiary populations, and benefit structures. Legislative direction to facilitate beneficiary-focused collaboration that also results in better management practices, resource use, accountability, and budget savings is a worthy goal for your Committees.

WHO ARE THE DOD BENEFICIARIES?

According to figures from the TRICARE Management Activity (TMA), there were 8.29 million eligible DOD health care beneficiaries, as of September 1, 2001:

Beneficiary category	Air Force	Army	Coast Guard	Marine Corps	Navy	Navy afloat	Other	Total
Active Duty	345,857	478,409	33,319	169,477	212,556	164,075	5,946	1,409,639
Active Duty Family Member	509,022	702,884	49,518	174,414	292,121	199,767	10,533	1,938,259
Guard/Reserve	21,323	86,827	502	3,557	19,753	.....	32	131,994
Guard Family Member	36,557	115,113	581	5,577	34,281	.....	46	192,155
Other	4,248	21,567	414	2,909	5,698	.....	1,475	36,311
Retiree	652,736	648,710	32,735	109,220	470,833	.....	4,106	1,918,340
Retiree Family Member	747,667	751,567	42,191	136,443	565,476	.....	4,539	2,247,882
Survivor	134,913	162,373	5,636	21,063	96,436	.....	651	421,076
Unknown	36	175	6	14	78	.....	5	315
Totals	2,452,359	2,967,625	164,902	622,674	1,697,232	363,842	27,333	8,295,972

Source: Population Summary, TRICARE Management Activity website: www.tricare.osd.mil/tools

As can be seen from the above chart, retirees, their family members, and survivors make up approximately half of the DOD beneficiary population. Active duty family members slightly outnumber active duty members. Since the terrorist attacks of September 11, more than 76,000 additional Guard and Reserve members have been called to active duty, thus adding to the beneficiary population. The families of Guard and Reserve members ordered to active duty for more than 30 days are eligible for health benefits under TRICARE immediately upon the servicemembers' activation. If the Guard or Reserve member is ordered to duty for a period exceeding 179 days, the family is automatically eligible to enroll in TRICARE Prime (see attachment 1, TRICARE Basics Fact Sheet, for a description of the three TRICARE options).

Who are today's military members and their families? The all-volunteer military today is predominantly a young, married force with children. Although the active duty force is older now than it was two decades ago, it is younger than the adult civilian population. Nearly 80 percent of active duty personnel are below age 35; 100,000 of the 1.4 million active duty members are teenagers. Currently, 53 percent of both the active force and reserve component is married; 56 percent of the active duty married population is between the ages of 22 and 29. Women make up 14.5 percent of the active force and 17 percent of the Guard and Reserve components. Studies show that military members tend to marry younger, begin to have children at a younger age, and have larger families than their civilian peers. More than 45 percent of military members have children. Nearly 900,000 children, or 73 percent of all military children in active duty families, are under age 11; 39 percent are five

years of age or younger. Six percent of active duty members have family members with special needs.[2]

WHAT ARE THE HEALTH CARE NEEDS OF DOD BENEFICIARIES?

The DOD Health System must provide not only the health care needed to maintain and support the military force, but also the employer-sponsored health care benefit to which active duty families, retirees and their families, and survivors are entitled. Active duty families need to know that the active duty member has received the health care needed to be physically ready for the mission, that quality health care is available at the field hospital or aboard the ship, and that deployment-related health conditions are being identified, evaluated, documented, and treated. Active duty members need to know that their family is being cared for when they are on a mission away from home—that sick children are seen by qualified and caring medical personnel, that prescriptions are available, and that the family does not encounter unexpected medical costs. They need to know that this quality health care benefit is portable, available for themselves and their families wherever their military Service orders them to move. Some of the greatest frustrations with the TRICARE system among active duty families relate to portability issues: understanding how to access care when traveling or when between assignments, transferring enrollments from one region to another, and learning the different requirements of individual Military Treatment Facilities (MTFs) and regional Managed Care Support Contractors.

Military retirees also want access to the full range of the TRICARE health care benefit to which they, their families, and survivors are entitled because of their years of service. All DOD beneficiaries, as do all Americans, want and expect quality health care in a patient-friendly environment. TRICARE Customer Satisfaction Surveys show that DOD beneficiaries also value continuity of care; seeing a provider who knows one's medical history is important to all beneficiaries, not just those with chronic conditions. After years of not expecting this kind of continuity in the DOD system, beneficiaries see the system trying to improve continuity of care and preventive health measures by assigning TRICARE Prime enrollees to a Primary Care Manager (PCM) or primary care team. Approximately 90 percent of eligible active duty family members are enrolled in the HMO-like TRICARE Prime, many because they want the guarantees of primary care with the same doctor or in the same clinic on each visit. Enrollment in Prime enables them not only to have a primary care manager but also gives them priority for care in the MTF. Other DOD beneficiaries, however, cite the importance of continuity of care as the reason why they stay with the more expensive option of TRICARE Standard rather than enrolling in Prime. Military PCM's, they say, often must deploy; they also move, just like other active duty members.

Access to care with the proper provider in a timely manner is also valued by DOD beneficiaries. The Congressionally mandated DOD Health Care Quality Initiatives Review Panel noted in its report, issued in 2001, that for DOD beneficiaries access to care cannot be separated from any discussion of quality. In fact, limited access was the major quality issue raised by beneficiaries.[3] At many locations in the pre-TRICARE era, when beneficiaries called for appointments, especially for specialty care, they were often told there were no appointments available and to "call back next month." With the advent of TRICARE came the guarantee of access standards for TRICARE Prime patients (see attachment 1). These access standards covering both accepted driving distance to a provider and the time in which an appointment must be made mark one of the greatest differences between the TRICARE benefit for DOD beneficiaries and the VA health care benefits. Although Prime beneficiaries in some locations occasionally are told that an appointment with the needed provider is not available within the prescribed time or distance, citing the access standard to the appointment clerk usually gets results!

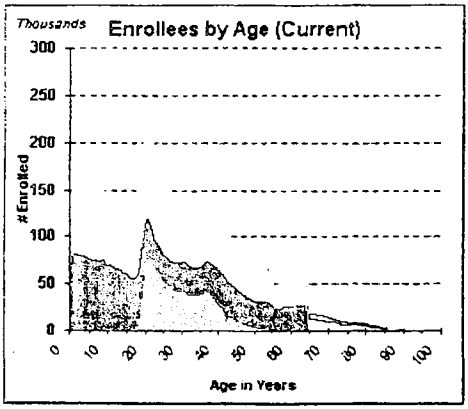
Having the proper provider mix in the network is important given the demographics of the TRICARE Prime beneficiary population. The following chart shows that the age of the TRICARE Prime enrollees is heavily skewed toward a young population. Therefore, robust TRICARE networks need pediatricians, family practice

[2] Demographic information in this paragraph has been obtained from the Profile of the Military Community: 2000 Demographics, prepared for the Deputy Assistant Secretary of Defense for Military Community and Family Policy by the Military Family Resource Center, available at www.mfrc.calib.com.

[3] The Final Report of the DOD Healthcare Quality Initiatives Review Panel, submitted to Congress in early 2001, will shortly be accessible via the TRICARE website: www.tricare.osd.mil. Until the report is posted, NMFA suggests that persons interested in obtaining the report contact the office of the TRICARE Management Activity Medical Director.

doctors, and obstetricians. TMA reports that the number one inpatient discharge diagnosis in the military system is "single, live births in hospital without Caesarean section". The second most common diagnosis is "single live births in hospital with Caesarean section." The commander of the MTF at Fort Bragg, NC, has summed up his facility's business as primarily "bones and babies." The chart on the following page shows the age breakdown for current TRICARE Prime enrollees. This chart, plus knowledge of the mission of the soldiers at Fort Bragg, provides verification of the truth of the MTF commander's statement:[4]

[4] Source: Enrollment Reports, TRICARE Management Activity website: www.tricare.osd.mil/tools. Chart includes enrollees in TRICARE Senior Prime Demonstration.



DOD beneficiaries assigned or living outside the catchment area of an MTF or at an installation with only a small military medical facility face the greatest health care access problems. In many locations, TRICARE Prime cannot be offered because the eligible population does not support the development of a Prime network. In other locations, an overall lack of providers, a lack of certain specialty care, or the reluctance of local providers to accept TRICARE reimbursement rates limit beneficiaries' access to care and increase their health care costs. Beneficiaries, both active duty families and retirees, have been forced to rely on the more expensive TRICARE Standard. In 1999, DOD implemented the TRICARE Prime Remote Program for active duty servicemembers such as recruiters or ROTC instructors located in areas with no Prime networks. The Department will soon implement the Prime Remote Program for Active Duty Family Members. Enrollment in this program will reduce families' costs to what they would be if they were enrolled in Prime and also provide them with assistance in finding providers. Retirees and their family members are not eligible for this program.

Although copayments for health care services have been eliminated for active duty families in TRICARE Prime, some families do occasionally need to submit claims for reimbursement for care received. Beneficiaries not enrolled in Prime and their providers expect prompt reimbursement at rates reflecting the actual costs of delivering the health care. TRICARE contractors have improved the processing of clean claims-those with no errors-but both beneficiaries and providers still report problems with the processing of more complicated claims, which are more likely to be sent back for corrections or which may be initially denied or subjected to review.

HOW CAN THE DOD AND VA COLLABORATE TO IMPROVE HEALTH CARE DELIVERY FOR BENEFICIARIES?

NMFA believes that current examples of collaboration, although not great in the monetary amounts involved, hold out possibilities for further partnering. We also note that there may exist other opportunities for collaboration between the two systems to improve health care delivery for both beneficiary populations. It is essential, however, that these opportunities be explored in the context of the needs of the two systems beneficiaries.

NMFA staff members have visited two of the joint arrangements currently operating. At both Elmendorf AFB, Alaska, and the Kirtland AFB/Albuquerque VA hospital site, we were impressed with the commitment of the staff to making the arrangement work for beneficiaries. We also noted the advantages gained in services and facilities under the joint arrangements and the savings that came from ending some duplication of facilities and services. One example of this savings was in the use of the VA's mammography equipment by the Air Force. By taking advantage of the availability of equipment not fully utilized by the VA, the Air Force clinic was able to avoid sending beneficiaries out in the network at a higher cost.

We have also been encouraged to read press reports recently of increased collaboration in the area of force protection and the monitoring of the health of deployed servicemembers (attachment 2). NMFA believes that collaboration is essential between the two systems on the development of baseline health measures and a common set of individual health records to evaluate a member's health status throughout his/her routine military physical examinations. This collaboration should extend

to medical screenings prior to deployment, the identification and evaluation of the effects of deployment-related conditions, the documentation of post deployment health changes, and the treatment and tracking of those conditions. Collaboration in force health protection measures, and in standardizing record-keeping and tracking procedures will pay off in better health care for servicemembers and for veterans.

Where available, more VA providers should be utilized as part of the TRICARE networks. Although many VA providers are also TRICARE network providers, it seems they have not been utilized extensively. NMFA hopes that the Congress will delve deeper to determine the reasons why VA providers and facilities have not been used to a greater degree by DOD beneficiaries. Some of the possible reasons we have identified for why this use has not occurred are:

- VA providers are not qualified in specialties most in demand by DOD beneficiaries.
- DOD beneficiaries are not referred to VA providers at the same rate as to other network providers either because of lack of knowledge of their availability or patient reluctance to use VA.
- VA providers cannot meet TRICARE Prime access standards.
- Claims processing and other administrative burdens impede use of VA providers by TRICARE Managed Care Support Contractors.

Expanding the use of VA providers as TRICARE-authorized providers who will treat TRICARE Standard beneficiaries may also improve retirees' access to care in areas where Prime is not available.

The DOD and VA are collaborating in contracting, administrative and maintenance services, and purchasing. This variety of arrangements, if properly administered and evaluated, could provide models for future collaboration. We believe the two systems can and should work closer together to develop health care quality measures, graduate medical education, and centers of excellence for certain specialty care. NMFA requests, however, that the Congress encourage collaborative ventures as part of an overall strategic initiative. Driving this strategic focus should be the needs of the systems' beneficiaries. Planning at the Department level can result in the empowerment needed by local military and VA staff to collaborate on health care initiatives to meet the needs of the beneficiaries in their locations. When NMFA staff visited the Joint-Venture arrangements in Alaska and New Mexico, we were impressed with the DOD and VA staffs' commitment to make the ventures succeed. Unfortunately, we also came away with the conclusion that the partnerships seemed to be based on an over-reliance on the local staffs' personal commitment rather than on the support, facilitation, and guidance available from the headquarters level. Certain issues, especially those involving budgeting, technology, and funds transfers, seemed to cause difficulties for the staff each time they arose.

Rather than beginning with a look at what facilities could be combined, for example, or how pharmacies or the pharmacy formularies could be integrated, we ask that the Congress look at how the delivery of two different benefits to two different beneficiary populations in the context of two different missions can be accomplished. What changes are needed at the department level, what support is needed to empower local leaders to engage in collaborative efforts? Integrating the systems' pharmacy program is one example of an initiative needing intensive work at the system level. Currently, if a DOD beneficiary was allowed to pick up medication at a VA pharmacy prescribed by a DOD or civilian TRICARE network provider, that beneficiary would have to forgo an important benefit available in the DOD system: access to the Pharmacy Data Transaction Service (PDTS). The PDTS not only checks on whether the beneficiary has gotten the prescription somewhere else, but also provides the pharmacist with information on any possible drug interactions. Local VA and DOD staff cannot solve this problem; leadership at the headquarters level is needed to provide the direction and resources to bring compatibility to pharmacy transactions, patient records, claims processing, and other technology.

Beneficiary buy-in is very important in any effective collaborative project. Beneficiaries need to feel that they have gained something and that someone is protecting their benefit. Because of the systems' different missions and beneficiary populations, beneficiaries have developed strong perceptions about the capabilities of each system to deliver their benefit. Well-publicized problems with both systems must be overcome before successful widespread collaboration can occur. The DOD must overcome access issues in some communities and continue to improve the claims process. The VA's problems with claims processing and patient access are even more well-known and constant publicity about these problems send a message to beneficiaries from both systems that they may not get the care they need.

Among the most important strategic issues to be considered in any planning for collaboration is the issue of accountability. A DOD beneficiary whose claim is re-

peatedly denied or who cannot find a provider sometimes views the multiple chains of command in the Defense Health System as a tangle that leaves no one in charge and no one accountable for looking after them. DOD beneficiaries in the United States must deal with the bureaucracies in DOD Health Affairs, the TRICARE Management Activity, 11 TRICARE Regions administered by 11 military Lead Agents and managed by 4 different contractors using a variety of subcontractors and 2 claims processors, their military Service medical commands (the Army alone has 6 commands covering the 50 states), and finally, the leadership of their local military treatment facility. NMFA urges the Congress to exercise caution before throwing another system with 22 VISNS, 163 hospitals, and several hundred other facilities into the mix. When a DOD beneficiary's PCM writes a specialty referral and the MTF Health Care Finder finds an appointment for him/her with a provider in the VA, and records get lost or a test is not properly authorized, who is accountable for making things right for the beneficiary? We have noted that often, when everyone is "supposed" to watch out for the beneficiary, no one is really held accountable. Our concern about accountability and leadership extend to the highest levels: who will settle disagreements between the Departments at the headquarters level about priorities and resource allocations? How will Congressional oversight responsibilities be allocated for these collaborative efforts?

We ask the Congress to encourage a strategic look at collaboration from the standpoint of how the headquarters levels of both the Department of Defense and the Department of Veterans' Affairs can empower local leaders to work together. We ask you to ensure that proper measures are in place to hold the Departments accountable for delivering quality health care for both DOD and VA beneficiaries. By thinking strategically and always focusing on desired outcomes for beneficiary health and satisfaction, the Departments can significantly increase collaborative efforts to benefit not only the beneficiaries but also the systems and the American taxpayers.

ATTACHMENT 1

TRICARE MANAGEMENT ACTIVITY FACT SHEET

TRICARE: THE BASICS

TRICARE is the Department of Defense's worldwide health care program for active duty and retired uniformed services members and their families. TRICARE consists of TRICARE Prime, a managed care option, TRICARE Extra, a preferred provider option, and TRICARE Standard, a fee-for-service option. TRICARE For Life is also available for Medicare-eligible beneficiaries age 65 and over (effective Oct. 1, 2001).*

TRICARE Prime

TRICARE Prime is a managed care option similar to a civilian health maintenance organization (HMO). It is the only TRICARE option that requires enrollment. Active duty service members are required to enroll in Prime. Active duty family members, retirees and their family members are encouraged, but not required, to enroll in Prime. Ask your local TRICARE service center (TSC) about the TRICARE Prime availability in your area. If you are stationed in a remote area, TRICARE Prime Remote may be the option available to you and your family members.*

TRICARE Prime offers less out-of-pocket costs than any other TRICARE option. Active duty members and their families do not pay enrollment fees, annual deductibles or co-payments for care in the TRICARE network. Retired service members pay an annual enrollment fee of $230, for an individual, or $460 for a family, and minimal co-pays apply for care in the TRICARE network. Although Prime offers a "point-of-service" option for care received outside of the TRICARE Prime network, receiving care from a non-participating provider is not encouraged.*

TRICARE Prime enrollees receive most of their care from military providers, or from civilian providers who belong to the TRICARE Prime network. Enrollees are assigned a primary care manager (PCM), who manages their care and provides referrals for specialty care. All referrals for specialty care must be arranged by the PCM to avoid point-of-service* charges.

TRICARE Prime enrollees are guaranteed certain access standards for care. The chart below describes the access standards for Prime enrollees.

	Urgent care	Routine care	Referred/specialty care	Wellness/preventive care
Appointment wait time	Not to exceed 24 hours.	Not to exceed 7 days	Not to exceed 30 days	Not to exceed 30 days

	Urgent care	Routine care	Referred/specialty care	Wellness/preventive care
Drive time		Within 30 minutes from home.	Within 60 minutes from home.	
Wait time in office		Not to exceed 30 minutes for non-emergency situations.		

TRICARE Extra & TRICARE Standard

TRICARE Extra and TRICARE Standard are available for all TRICARE-eligible beneficiaries who elect not to enroll in TRICARE Prime. Active duty service members are not eligible for Extra or Standard. There is no enrollment required for TRICARE Extra or Standard—no annual enrollment fees, no enrollment forms. Beneficiaries are responsible for annual deductibles and cost-shares. Beneficiaries may see any TRICARE authorized provider they choose, and the government will share the cost with the beneficiaries after deductibles.

TRICARE Extra is a preferred provider option (PPO) in which beneficiaries choose a doctor, hospital, or other medical provider within the TRICARE provider network. Network providers can be located by calling your local TRICARE service center or visiting our Web page.

TRICARE Standard is a fee-for-service option. You can see an authorized provider of your choice. People who are happy with coverage from a current civilian provider often choose this option. Having this flexibility means that care generally costs more. See the chart below for the differences between Extra and Standard.

	TRICARE Extra	TRICARE Standard
Physician/provider	In network	Not in network, but still an authorized provider
Cost share after deductibles	5% less than Standard	20% active duty families 25% retirees and their families plus the difference between the TRICARE allowable charge and the doctor's billed charge

TRICARE For Life and TRICARE Plus

When beneficiaries age 65 and over become eligible for Medicare Part A, they can use TRICARE For Life (TFL)* if they enroll in Medicare Part B. These beneficiaries are not eligible for TRICARE Prime, but are eligible to use network and non-network providers under TRICARE Extra and TRICARE Standard. Under TFL, TRICARE acts as a second payer to Medicare for benefits payable by both Medicare and TRICARE. Beneficiaries can use an authorized Medicare provider and claims will be automatically sent to TRICARE after Medicare pays its portion. There are no enrollment fees for TFL—beneficiaries are only required to pay the Medicare Part 6 premium. TRICARE is first payer for benefits such as pharmacy, which are available only under TRICARE.

Some military treatment facilities will have capacity to offer a primary care affiliation program called TRICARE Plus.* Enrolled beneficiaries have priority access to care at military treatment facilities, however, beneficiaries who choose to use TRICARE Extra, TRICARE Standard or TRICARE For Life may also continue to receive care in a military treatment facility as capacity exists.

For more information about any of the TRICARE options, please contact your local TRICARE service center or visit the TRICARE Web site at *www.tricare.osd.mil.*

ATTACHMENT 2

[From the New York Times, January 8, 2002]

U.S. TO IMPROVE MEDICAL MONITORING OF ITS TROOPS OVERSEAS

(By John Files)

WASHINGTON, Jan. 7.—In an effort to avoid lingering health problems for troops sent overseas in the war on terrorism, the Defense Department said today that it was taking measures to improve medical monitoring of its personnel.

Military officials said they were keeping careful records for troops and requiring service members to complete a simple medical screening before and after they were sent abroad. In addition, the armed forces are beginning to convert medical records for each service member to an electronic database.

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*See also: TRICARE For Life Fact Sheet; TRICARE Plus Fact Sheet; TRICARE Regional Managed Care Support Contractors Fact Sheet; TRICARE Prime Remote Web site.

The focus on the military's health needs and concerns during the operation in and around Afghanistan is a response, in part, to thousands of complaints from veterans of the Persian Gulf war who reported mysterious symptoms after they returned to the United States.

"We have tried to learn about the issues that caused them concern about their health," said Michael E. Kilpatrick, director for deployment health support at the Pentagon. He said the military had "a new mind-set" for handling the long-term health of its troops.

"We are trying to train people to ask questions, which is a change in military culture," Dr. Kilpatrick said. "Senior leaders need to understand that there is a major shift."

More than 100,000 troops who served in the gulf war say they suffer from a range of maladies including memory loss, anxiety, nausea, balance problems and chronic muscle and joint pain.

The government reported this month that gulf war veterans were nearly twice as likely to develop Lou Gehrig's disease as other military personnel. It was the first acknowledgment of a scientific link between service in the gulf and a specific disease.

Dr. Kilpatrick said that expanded use of the Internet by those who want to research health issues and to get medical information has forced the military to be more open about how it protects its personnel.

"Consumers are simply more aware now," he said. "We have to be prepared to explain why we believe things are safe. And we need to collect data and follow conditions over time."

The military, Dr. Kilpatrick said, is tracking the cases of service members who seek medical assistance while they are overseas for problems that are not related to combat, for example. And the Pentagon has started environmental monitoring for areas where it sends troops.

"We have traditionally paid attention to bombs, and rockets and distribution of anununition," Dr. Kilpatrick said. "Now we're looking at diesel fuel explosions, the preservatives in food that is stored over a long time and the safety of our vaccines."

Dr. Francis L. O'Donnell, who is in charge of the medical-readiness department at the Pentagon, said the measures also help officials identify pre-existing conditions. This is important, he said, when reservists and the National Guard are sent out quickly.

But some contend that the Department of Defense is not doing enough to care for American troops and to collect medical data from military conflicts.

Steve Robinson, executive director of the National Gulf War Resource Center, an umbrella group for organizations representing gulf war veterans, said troops should have full physical exams before, during and after assignments abroad—including the collection of blood samples.

The results of blood samples, and other medical data, could be compared with those collected before and after troops were in the field, he said, to find changes in an individual's health status, as well as to study conditions shared among a group of service members.

ATTACHMENT 3

[From the Fayetteville Observer, January 9, 2002]

WIDOW FIGHTS FOR VA CLAIM

(By Tanya S. Biank)

Mary Van Regenmorter wasn't about to let her husband miss his long-awaited doctor's appointment—even if he had died six weeks earlier. "He would not have missed an appointment," she said. So early on Nov. 19, she placed Kenneth's ashes in a bag along with his death certificate and her needlepoint and made the 2½-hour trip to the Veterans Benefits Administration's regional office in Winston-Salem.

Kenneth Neil Van Regenmorter, a retired master sergeant and Green Beret Vietnam veteran, had waited more than a year for the Benefits Adminstration to schedule an appointment for his physical. The exam is usually required when a veteran seeks disability benefits.

THE SYSTEM FAILED US

Phone calls from the Van Regenmorter and letters from doctors at Womack Army Medical Center describing his rapidly declining health did little to expedite an ap-

pointment date. A week after Kenneth Van Regenmorter died of congestive heart failure, a letter arrived with a Nov. 19 appointment date in Winston-Salem. "The system failed us," said Mary Van Regenmorter, who is also an Army veteran. "So I decided, if they want to see him, they are going to see him."

When she walked into the examining room, the doctor asked where her husband was. "We have to examine the veteran here," he told her. "And I pulled him out of the bag," she said. Kenneth Van Regenmorter's ashes were still in the box from the funeral home. The doctor was not amused. And neither was Mrs. Van Regenmorter. "I think the system really let us down," she said.

In order for veterans to receive disability benefits, they must have a disability or condition incurred while in service or a short time after. But establishing that eligibility can be a problem, because Benefits Administration offices across the country are buried in claims from veterans seeking disability compensation.

The administration examines documents, medical records and, in most cases, the veteran, then decides if a disability is service-connected and, if so, how much payment a veteran should receive. Officials say a lack of money, staffing and an adjustment to new regulations have contributed to the backlog. For some veterans applying for disability, it can take six to nine months before they are seen for an exam. At the administration office in Winston-Salem, about 36 percent of veterans' claims are more than six months old. That equates to 7,300 claims. The office's goal is to cut that number in half by next October.

"We share their frustrations at the delays and the process," said Vince Hancock, a management analyst and public affairs assistant at the administration in Winston-Salem. Hancock said the director at the regional office constantly reminds staff. "These are not claims, these are not pieces of paper; these are human beings, whose lives will depend on our decision." "We can't always give them a favorable decision," Hancock said. "But we owe them a prompt decision one way or the other."

It's not just a local problem. There are 574,000 claims pending nationwide. The Benefits Administration has a goal of reducing that number to 250,000 by 2003.

North Carolina ranks third in the nation behind Florida and Texas for the largest claims workload. The state has 768,000 veterans, 33,000 living in Cumberland County. The Veterans Benefits Administration's regional office in Winston-Salem handles all claims for the state. The office pays disability benefits to 88,359 veterans and 21,580 surviving dependents in North Carolina, which equates to $64.5 million each month. Hancock said the office gets 2,100 claims a month and has 19,500 pending claims, with a mandate to reduce the number to 12,200 this year and 10,000 by 2003.

BACKLOG FRUSTRATIONS

According to the North Carolina Division of Veterans Affairs, Cumberland County has more than 12,000 veterans receiving VA disability benefits. Last year, the county's veterans' service office helped 10,000 veterans establish or reopen claims. "Most complaints are from backlogs or frustrations with the system," said Mark Bergman, the county's director of veterans services. "I'm very honest with (veterans)," Bergman said. "It can take a full year. Most of the time it doesn't. The more documentation you can send the VA, the better off you are. And that's what I tell people."

One of the Benefits Administration's duties is to assist veterans in obtaining medical records. One patient can have medical records dating back years to several hospitals across the country. One of the problems, officials say, is that once those records are archived at the National Personnel Records Center in St. Louis, it can take months to retrieve them. The center houses 80 million records, including those of discharged, deceased and retired veterans. It is notorious for its backlog in records requests. In 2000, the Department of Veterans Affairs hired 21 employees and in 2001, another dozen to work at the center pulling records needed for claims.

The Benefits Administration had a 13 percent budget increase this year targeted for improvements in timeliness and accuracy. This past year, 1,100 employees were hired as claims examiners and disability rating specialists. The agency also got a new computer system used for tracking claims. "We have started to see some improvement," Hancock said. But is it too late for the Van Regenmorter family? Maybe not.

SURVIVOR'S CLAIM

The claims process usually dies with the veteran. But a surviving spouse can make a claim for accrued benefits. Which means Mary Van Regenmorter could receive back pay from the day her husband filed his claim to the day of his death.

Kenneth Van Regenmorter was 51. He had filed 12 claims for a host of health problems, including hearing and vision loss, diabetes, hepatitis and high blood pressure. The administration is reviewing his files for disability as well as service-connected death benefits for Mary Van Regenmorter and the couple's 11-year-old daughter. A decision should be made by the end of the week, Hancock said.

Hancock said getting records from the National Personnel Records Center caused much of the delay. But he also said that his office "dropped the ball" once the last set of records was received on Sept. 4, 2001. "Those records came in on the fourth, and rather than being identified as an expedited claim that was already a year old, it just kind of went through normal channels and it took us about 30 days then for it to be reviewed and then for an exam to be set up," he said.

Mary Van Regenmorter said her husband should have filed for disability years ago, but his pride got in the way, she said. "He refused to do disability," she said. "He felt it was your job to do what you can for your country. He felt that the service would take care of him."

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DEPARTMENT OF VETERANS AFFAIRS AND DEPARTMENT OF DEFENSE HEALTH RESOURCES SHARING

STAFF REPORT TO THE
COMMITTEE ON VETERANS' AFFAIRS

U.S. HOUSE OF REPRESENTATIVES
107TH CONGRESS

FEBRUARY 25, 2002.—Printed for the use of the Committee on Veterans' Affairs of the House of Representatives

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DEPARTMENT OF VETERANS AFFAIRS AND DEPARTMENT OF DEFENSE HEALTH RESOURCES SHARING

STAFF REPORT TO THE COMMITTEE ON VETERANS' AFFFAIRS

Purpose.—This staff report to the Chairman and Ranking Member of the Veterans' Affairs Committee is intended to analyze the current status of health resources sharing between facilities of the Department of Veterans Affairs (VA) and Department of Defense (DoD). The law authorizing sharing was enacted in order to make better use of such facilities and to improve access to quality health care for beneficiaries of both departments. This report also discusses new opportunities for enhancing sharing authority and recommends legislation to achieve more VA-DoD resource sharing.

BACKGROUND

Veterans Administration and Department of Defense Health Resources Sharing and Emergency Operations Act.—In 1982, Congress enacted the Veterans Administration and Department of Defense Health Resources Sharing and Emergency Operations Act, Public Law 97–174, 38 U.S.C. 8111, (the Sharing Act) to foster more effective sharing of health care resources between the former Veterans Administration, now the Department of Veterans Affairs, and the Department of Defense. Previously, VA and DoD health care facilities, many of which are co-located or in close geographic proximity, operated virtually independently of each other. This occurred despite opportunities to enhance access and quality of service for beneficiaries, and save funds through shared clinical care and joint procurement. The intent of the law was not only to remove legal barriers, but also to provide incentives for military and VA health care facilities to engage in sharing through local agreements, joint ventures, national sharing initiatives, and other collaborative efforts to more effectively and efficiently use Federal health resources.

The Sharing Act gives local health care executives flexibility in establishing sharing agreements, including conducting negotiations, developing reimbursement methods and bartering services, as well as streamlining the review and approval processes to minimize bureaucratic delay from Washington. As an incentive to share, it provides that a facility furnishing services retain funds earned from such sharing. To encourage establishment of sharing as an important priority, the Sharing Act requires the VA's Under Secretary for Health and DoD's Assistant Secretary for Health Affairs to recognize health resources sharing as an ongoing respon-

sibility. The Sharing Act has been amended three times in response to proposals by the departments to improve the relationship between them. Currently, a Presidential Task Force to Improve Health Care Delivery for our Nation's Veterans is reviewing VA and DoD policies and practices relating to sharing to identify new or potential opportunities and make recommendations to the VA and Congress to promote increased sharing.

The VA-DoD annual report to Congress in January 2000 depicted sharing as a robust program with "virtually all" VA and DoD facilities involved. In reality, however, while VA and DoD have increased sharing in sheer dollar volume and added many new agreements over the past twenty years, the total amount of sharing remains miniscule as a percentage of the two departments' combined health care outlays. According to VA's Office of Medical Sharing, in fiscal year 2001 VA and DoD shared services valued at only $58 million out of the two departments' total health care budgets of approximately $35 billion—about two-tenths of one percent of their medical spending.

Congressional Commission on Servicemembers and Veterans Transition Assistance.—The difficulties in VA-DoD sharing are already a matter of record. The January 1999 Report of the Congressional Commission on Servicemembers and Veterans Transition Assistance questioned whether the two departmental health care systems could survive as separate entities unless they continued to receive funding supplements, or restructured and realigned with each other. To improve their prospects the Commission recommended:

- Joint procurement of pharmaceuticals, medical and surgical supplies, and medical equipment.
- Interoperable clinical, management and financial information systems.
- Joint procurement of health information technology.
- Development of compatible cost accounting systems and a joint resource allocation and budgeting process.
- Combined funding of graduate medical education.
- Recognition of VA medical centers as equivalent to military treatment facilities in DoD's TRICARE community health program for military retirees and dependents.
- Combined policy staff and process to review health facilities construction requirements.

The Commission reported that it was imperative for the departments to enter into a "true partnership" and restructure their organizations to overcome cultural and institutional barriers that needlessly separate them.

There are over 400 active health care sharing agreements and eight joint ventures between VA and DoD involving 150 facilities. However, about 75 percent of the $62 million in sharing currently reported is derived from agreements at only 30 sites.

Inpatient Care.—About 75 percent of shared inpatient care (defined as acute bed care of more than 24 hours in duration) is provided at only 12 locations: Madigan Army Medical Center, Ft. Lewis, WA; 5th Medical Group, Minot AFB, ND; 319th Medical

Group, Grand Forks AFB, ND; Ralph H. Johnson VA Medical Center, Charleston, SC; Walter Reed Army Medical Center, Washington, DC; Brooke Army Medical Center, Ft. Sam Houston, TX; 375th Medical Group, Scott AFB, IL; Oklahoma City VA Medical Center, Oklahoma City, OK; Overton Brooks VA Medical Center, Shreveport, LA; John L. McClellan Memorial Veterans Hospital, Little Rock, AR; Bassett Army Community Hospital, Fort Wainwright, AK; and James A. Haley Veterans Hospital, Tampa, FL.

Ancillary Services.—Most shared ancillary care (defined primarily as nuclear medicine, radiology and laboratory services) is provided at 12 sites: VA Pittsburgh Health Care System, Pittsburgh, PA; Tomah VA Medical Center, Tomah, WI; Walter Reed Army Medical Center, Washington, DC; Arnold Air Force Station, Tullahoma, TN; 5th Medical Group, Minot AFB, ND; Sam Rayburn Memorial Veterans' Center, Bonham, TX; Dayton VA Medical Center, Dayton, OH; Moncrief Army Community Hospital, Fort Jackson, SC; Alvin C. York VA Medical Center, Murfreesboro, TN; Bassett Army Community Hospital, Fort Wainwright, AK; Madigan Army Medical Center, Fort Lewis, WA; and Houston VA Medical Center, Houston, TX.

SITE VISITS

During 2001, Committee on Veterans' Affairs staff conducted fact-finding site visits to VA and military treatment facilities in West Los Angeles and San Diego, CA; Las Vegas, NV; Albuquerque, NM; San Antonio, TX (accompanied by House Committee on Armed Services staff); El Paso, TX; Charleston, SC (accompanied by House Committee on Armed Services staff and staff of Rep. Henry Brown); Fayetteville, NC (accompanied by staff of the General Accounting Office (GAO)); and Chicago, IL (accompanied by GAO and staffs of House Appropriations Subcommittee on VA, HUD and Independent Agencies, Sen. Richard Durbin, Sen. Peter Fitzgerald, and Rep. Mark Kirk). [1]

Los Angeles, CA.—The West Los Angeles VA Medical Center, the VA's largest, is approximately 12 miles from Los Angeles Air Force Base in El Segundo, CA. The Greater Los Angeles VA Healthcare System consists of five ambulatory care centers, eight community based outpatient clinics, the largest medical research program within the VA, and the tertiary care medical center. This VA health care system provides a full spectrum of services to over one million veterans residing in the primary service area. These services include comprehensive medical, surgical, psychiatric, diagnostic, and treatment services, as well as psychiatric specialty programs and comprehensive rehabilitation programs. In addition, the health care system operates a 321-bed domiciliary program and two 120-bed nursing home units.

The fiscal year 2001 budget of the health care system was $384 million. Fiscal year 2001 VA-DoD sharing amounted to only $24,724. Currently, the VA provides limited mental health services to DoD beneficiaries at Los Angeles AFB. The Air Force is building a new outpatient clinic that is expected to open in mid-June 2002.

[1] See Appendix I for site visits and contacts.

There was little evidence of any attempt by the Air Force or the VA to consider a joint venture or partnership arrangement for this facility. Joint staffing issues, reimbursement methodologies and contract negotiations were frequently mentioned as barriers to greater sharing, as well as differences in the beneficiary populations' needs.

San Diego, CA.—The VA San Diego Healthcare System is a major medical, surgical, psychiatric, tertiary, and community care system with a medical center located in La Jolla and community clinics located in Mission Valley, El Centro, Chula Vista, and Vista. It had a fiscal year 2001 budget of $202 million. The medical center, which is a regional center for cardiac surgery and spinal cord injury, has 238 inpatient beds with a 69-bed extended care center and a 30-bed spinal cord injury center. The medical center provides outpatient care through numerous clinics, including the four community clinics named above. This VA health care system also provides ambulatory surgery, rehabilitation, prosthetics, audiology, optometry, and home health care. Specialized programs include PTSD counseling, Agent Orange and Persian Gulf War screening, alcohol and drug treatment programs, and programs for homeless veterans. The health care system collaborates with the University of California at San Diego School of Medicine and operates a large medical research program.

Balboa Naval Medical Center San Diego is a 392-bed tertiary medical center that had a fiscal year 2001 budget of over $388 million. It operates a network of clinics located at area military installations and provides emergency and ambulatory care to the active duty population of all San Diego-based ship and shore commands. The naval medical center also conducts graduate medical education with about 20 different medical disciplines. It is a partner in a sharing agreement with the San Diego VA Healthcare System. Balboa sends its referrals to the TRICARE civilian network, but the VA medical center is not part of the TRICARE network because its management believes it cannot compete with the three civilian medical centers in the area. Balboa is 15 miles from the VA medical center.

Sharing revenue generated between these VA and DoD facilities in the San Diego area was $117,183 for fiscal year 2001. There are graduate medical education agreements among the Navy, the VA and the University of California at San Diego School of Medicine pursuant to which the VA provides resident training for Navy doctors. The VA also provides outpatient and ancillary services for a branch DoD clinic, and the facilities reported that they were finalizing an agreement to share a community clinic that will serve veterans and the military community.

However, both facilities' executives expressed the belief that sharing opportunities are limited because of differences in patient populations. Each facility is large, complex and offers all levels of care with no excess capacity from primary to tertiary care, including complex surgery. Also, the facilities use different financial and clinical data management systems. They reported that frequent rotations of senior Navy personnel created difficulty in maintaining

working relationships and continuity of shared programs, especially in the clinical area.

Las Vegas, NV.—The Mike O'Callaghan Federal Hospital at Nellis AFB outside Las Vegas is a 96-bed Air Force-managed hospital with 52 VA-dedicated beds. The facility opened in 1994. The VA also has a full spectrum outpatient clinic, a stand alone psychiatric day treatment center, two community-based primary care clinics, and a community based outreach center in Las Vegas dedicated solely to the care of homeless veterans. Although this is a unique joint venture of VA and the Air Force's 99th Medical Group, each partner maintains separate budget, financial, human resources and clinical data management systems. The Air Force's budget for fiscal year 2001 was $30 million and the VA's was $16.8 million.

While this facility was planned and built as a "Federal" facility, opportunities to enhance sharing under the Sharing Act have not been explored or have been abandoned. For example, the two separately maintained pharmacies, one for veterans and another for Air Force personnel, retirees and family members, could be consolidated. Also, VA's existing Consolidated Mail Outpatient Pharmacy system could be utilized by DoD beneficiaries in the region; the budgeting, accounting, data and human resources management systems could be combined; management of the separate intensive care units could be merged, along with surgical operating rooms, support facilities and staff; and a common medical record could be established. Such changes would offer dramatic improvements in efficiency and could promote the establishment of new programs that would benefit veteran and military beneficiaries alike.

Albuquerque, NM.—The Albuquerque VA Medical Center and Kirtland AFB Hospital co-location established in 1987 was the inaugural VA-DoD health resources joint venture. There are approximately 186,000 veterans in the area served. In addition to tertiary care, the facility provides primary and secondary care. The facility also provides for the referral of specialty care by the Kirtland AFB clinic to VA physicians. This special partnership offers VA admitting privileges to Air Force physicians. The system currently operates five community based outpatient clinics and has partnered with federally qualified health centers to offer veterans further access to clinics in 13 rural locations throughout the state. The relationships between these facilities have been significantly altered over the duration of their partnership. The original arrangement was that the Air Force operated a separate, 40-bed hospital within the Albuquerque facility. Air Force health command downsizing has resulted in a complete inpatient closure, and the Air Force now purchases all inpatient clinical care services from the VA.

The VA medical center's fiscal year 2001 budget was $186 million, and the Air Force's was $17.6 million. In fiscal year 2001, total sharing revenue was reported to be $6.8 million. While many of the observations of lost opportunities to share observed in Las Vegas do not pertain to Albuquerque, others do. For example, the Air Force and VA needlessly maintain separate dental clinics with separate supply chains and central dental laboratory functions. The Air Force also continues to maintain a management presence as if

it were still operating a separate facility, even though most of its health care services are duplicates of existing VA activities.

San Antonio, TX.—The South Texas Veterans Health Care System is comprised of the Audie L. Murphy, Satellite Clinic, and Kerrville Divisions. The Audie L. Murphy Division is a 294-bed tertiary care facility that provides acute care services to approximately 300,000 veterans in south central Texas. The hospital also contains a 90-bed nursing home unit and a 30-bed spinal cord injury center. The Satellite Clinic Division operates five outpatient clinics in San Antonio, Corpus Christi, Laredo, McAllen, and Victoria. The Kerrville Division provides 25 acute care beds and 154 nursing home care beds. The system is affiliated with the University of Texas Science Center at San Antonio, and supports a Geriatric Research, Education, and Clinical Center.

Brooke Army Medical Center provides primary, secondary, and tertiary care to a large beneficiary pool in Texas, Oklahoma, Louisiana, Colorado, Kansas, Missouri, and Panama. Brooke provides graduate medical education for about 550 students annually. It also provides emergency trauma care to 50 percent of the civilian population in San Antonio and houses the world-renown military Institute of Surgical Research Burn Center. The Army medical center is a new state of the art facility that had a fiscal year 2001 budget of $275.4 million. It has unused bed capacity due to low patient populations. Brook is approximately 17 miles from the VA's Audie L. Murphy Division.

Wilford Hall Medical Center at Lackland AFB is a comprehensive health care system and the Air Force's most important medical center. The facility has 280 beds and is a major referral center. Wilford Hall offers a full spectrum of specialty care and has the Air Force's only trauma center. This medical center has DoD's only allogenic bone marrow transplant center, the U.S. Air Force AIDS/HIV center, and the only stereo lithography in DoD. More than 600 clinical research projects are in progress. Wilford Hall is an older facility that will require major upgrades to maintain its accreditation, plus about $40 million in other needed major maintenance and facility renovations. Its fiscal year 2001 budget was $154 million. The facility is located 11 miles from the VA's Audie L. Murphy Division.

The San Antonio Health Council, which is comprised of the leadership from Wilford Hall, Brooke, VA and the University of Texas Health Sciences Center, is responsible for coordinating healthcare in the San Antonio area, including sharing. The combined medical budgets of the Air Force, Army and VA facilities are over $705 million. The DoD sharing revenue was $679,573.

El Paso, TX.—The VA El Paso Health Care System is a modern ambulatory care center that provides primary and specialized ambulatory services to approximately 74,583 veterans and also operates a community-based outpatient clinic in Las Cruces, NM. The clinic, completed in 1995, is adjacent to the Beaumont Army Medical Center. There is no VA hospital in El Paso, the closest VA hospital being 500 miles away in Albuquerque. Consultants and fee-basis specialists supplement the medical staff. Inpatient care for acute medical and surgical emergencies is provided through a VA-

DoD sharing agreement with William Beaumont Army Medical Center. Services that the VA El Paso Health Care System provide include primary care, urgent care, mental health services, social work, audiology, radiology, ophthalmology, podiatry, orthopedics, laboratory services, pharmacy and surgery. The center has a shared ambulatory surgery suite with eight operating rooms. Affiliation agreements for residency programs in internal medicine and psychiatry are administered through a consortium agreement with Texas Tech University and the Army medical center.

Charleston, SC.—Naval Hospital Charleston, now an outpatient facility, is a 1974-vintage, 350-bed hospital that was downsized as a result of the 1993 Base Realignment and Closure Commission. It now serves as an ambulatory care center providing primary and specialty care for local active duty Navy personnel, family members and retirees. Its fiscal year 2001 budget was $45.1 million. All Navy inpatient care is referred to the TRICARE provider network. Few referrals were made to the Ralph H. Johnson VA Medical Center, which is a designated TRICARE facility located only 6.5 miles away, reportedly because of a lack of capacity at the VA to handle additional inpatient workload.

The Ralph H. Johnson VA Medical Center is a primary, secondary, and tertiary care medical center providing acute medical, surgical, and psychiatric inpatient care, as well as primary and specialized outpatient services. The medical center is affiliated with the Medical University of South Carolina and has one of the leading open-heart surgery programs in the southeastern United States. It also conducts major medical research in diabetes, lipid disorders, heart disease, hematology, fetal alcohol syndrome, kidney disease, and rheumatology. Its fiscal year 2001 budget was $112.5 million. The facility was constructed in 1966 as a 500-bed acute care hospital. It reports an operating capacity of 115 beds, but due to a nursing shortage, only 92 beds are available for patient care admissions.

Both the VA and DoD Charleston facilities are outmoded for delivering health care in a modern and efficient manner. However, the State of South Carolina plans to replace the Medical University of South Carolina's academic health center adjacent to the VA Medical Center. No local plan has been developed, but it is conceivable that the three entities, the Navy, VA and the State of South Carolina, could become a unique example of cooperation in delivering health care by sharing a new multi-purpose federal-state academic health center for the military and civilian residents of eastern South Carolina.

A regional VA Consolidated Mail Outpatient Pharmacy (CMOP), one of eight such facilities nationwide, is located in Charleston and is across the street from the naval hospital compound. It produces 52,000 mailout prescriptions daily for eligible veterans throughout the southeastern United States. The executive staff of the Naval Hospital confirmed an awareness of its existence but had neither visited it nor considered its potential relevance to the naval hospital's pharmacy workload. The Navy reported difficulty recruiting and retaining pharmacy technicians because it could not offer competitive salaries for the Charleston area. Because of pharmacy per-

sonnel shortages, the Navy is experiencing difficulty maintaining its own mailout workload of about 500 daily prescriptions. The CMOP director informed the staff that the facility could easily accommodate an additional 500-prescription daily workload if Navy's requirement could be translated and incorporated into VA's regional automated order-entry network.

Fayetteville, NC.—The Fayetteville VA Medical Center, constructed in 1939, is primarily a long-term care center with a variety of active outpatient programs. The medical center serves 163,205 veterans and operates 157 beds, including a nursing home care unit. It provides acute medical, surgical and psychiatric care, as well as intermediate care. It opened a community-based outpatient clinic in February 1999 in Jacksonville, NC. Through a series of renovation projects, the medical center has a full array of inpatient and outpatient services. The medical center has affiliation agreements with 16 educational institutions covering 24 different areas of study.

Womack Army Hospital is located about 12 miles from the VA medical center. Dedicated March 18, 2000, Womack is the Army's newest medical center. It serves more than 160,000 eligible beneficiaries. The facility has three buildings, including a seven-floor inpatient tower, and exhibits the latest in technology and innovation. Some of the services provided include cardiology, hematology-oncology, pulmonology, and endocrinology. Fayetteville and Womack currently use a magnetic resonance imaging (MRI) unit jointly acquired in 1992. The use agreement will expire in May 2002. However, when the new hospital was built, the Army unilaterally purchased a new MRI unit, disregarding their previous MRI sharing. The result may be increased costs to VA as it sends patients to Womack for magnetic resonance imaging on a fee basis. The VA medical center shares other resources with both the Army hospital and Pope AFB under VA-DoD sharing agreements to augment health care delivery. Pope AFB is 4.8 miles away from Womack Army Hospital.

Womack was planned and built without an institutional laundry on the premise that the VA facility's laundry would accommodate the Army's workload under a sharing agreement. The VA spent $2.9 million to renovate its laundry for that purpose. However, Womack withdrew from this agreement because VA failed to maintain necessary minimal quality. Womack now has a 6-year contract for laundry service with a commercial vendor, and VA's laundry is operating at barely over 50 percent of its intended capacity.

Chicago, IL.—North Chicago VA Medical Center, a member of the VA Great Lakes Health Care System, provides area veterans with primary medical and psychiatric care, medical subspecialty care, ambulatory surgery, and physical medicine, rehabilitation, and supportive ancillary services. Community-based treatment teams provide both home-based primary medical care and psychiatric care for veterans with serious mental illnesses. The VA medical center operates the Evanston Primary Care Clinic adjacent to the Northside Veterans' Center in Evanston and hosts community health clinics throughout northern Illinois. Its primary affiliates are the Finch University of Health Sciences/Chicago Medical

School. The VA medical center also provides clinical experience to Navy corpsmen through a sharing agreement with the Great Lakes Naval Training Center, and it shares the same general military compound in Waukegan with the training center.

Naval Hospital Great Lakes offers a variety of specialty services. Although obstetrical services are not available at the naval hospital, such care is provided through local community hospitals. The naval hospital is part of TRICARE Region 5 under the military's new managed health care plan. The TRICARE Service Center offers benefits counseling, referral processing, enrollment processing and assistance locating providers that accept TRICARE and Medicare. The VA medical center provides the naval hospital with dental and support services and some inpatient, outpatient, and ancillary services. However, neither the Navy's current economic analysis of the naval hospital nor the VA's Capital Asset Realignment for Enhanced Services process addresses an opportunity to enter into a partnership to preserve essential medical infrastructure, promote military readiness and meet the needs of both beneficiary populations.

OBSTACLES TO SHARING

In most site visits, the Committee on Veterans' Affairs staff identified the following systemic obstacles that preclude or discourage VA and DoD facilities from developing or sustaining meaningful sharing arrangements:

- Absence of any statutory requirement for health resources sharing between the departments.
- Inadequate or outdated guidance from the Secretaries of Defense and Veterans Affairs on health resources sharing policy.
- Restrictive regulations, policies and procedures that inhibit health resources sharing.
- Incompatible methods to reimburse costs of services rendered to beneficiaries of the other department's programs.
- Unclear or unstated strategic goals for health resources sharing in either department.
- Absence of sharing goals for regional or facility executives in either department.
- Incompatible computer systems and healthcare workload reporting systems.
- Incompatible information technologies and lack of common information technology goals, resulting in dual entry of workload, duplicative data and wasteful methods of information retrieval.

Senior Management Issues.—Executive leadership is a key to meaningful VA-DoD sharing programs. VA and DoD assign executive personnel in their health care systems according to different internal administrative policies and practices. VA tends to assign its civil service health executives to facilities for long periods, sometimes entrenching poor management practices and promoting empire building. On the other hand, DoD limits military treatment facility commanders (as well as clinical program directors) to much

shorter assignment periods, typically no more than three years. At the change of command or reassignment of the VA medical center executive, agreements between previous executives and commanders may have to be renegotiated or even cancelled.

Health care facility executives of the VA, Army, Navy, Air Force, and Coast Guard are subject to annual performance evaluations. These evaluations focus on matters of policy execution with many common and some unique requirements (for example, readiness in a military treatment facility). The success or failure of a facility's sharing program, however, is rarely evaluated. Executives whose facilities share "too much" with a partner may be perceived as eroding the facility's financial, administrative or clinical foundations to the detriment not only of their facility but also of their careers. Thus, entering into sharing agreements with other federal agencies can be risky behavior, and may be approached cautiously or avoided.

Lack of Funding Incentives.—The Committee on Veterans' Affairs staff observed no positive funding incentives for health care facilities of either department to provide care for each other's eligible beneficiaries when it would be advantageous for the government to do so. In fact, the advent of TRICARE has introduced a powerful disincentive to the referral of military patients to nearby VA facilities. The referring military facility under TRICARE rules must identify a funding source within its allocation to reimburse the VA facility, but no such identification or payment need be made when a military patient is referred to the TRICARE network. Also, Committee staff observed that there are few incentives to jointly procure medical services, devices, supplies or capital equipment, even when the end-use of such goods or services is indistinguishable between the two departments.

Opportunities For Joint Activity

Graduate Medical Education.—Current DoD and VA graduate medical education programs should be reviewed for opportunities for greater collaboration. These opportunities would aid coordination of federal subsidies to the teaching hospitals. Both departments' graduate medical education programs must maintain a sufficient case mix for residency program certifications. Joint DoD and VA residency programs at co-located sites could ameliorate the effects of DoD military deployments. Maintaining competent specialty residency programs is a critical factor in wartime readiness. The Committee on Veterans' Affairs staff believes that DoD programs would benefit from joining VA academic partnerships through exposure to a more diverse clinical mix. Many of the techniques used in VA surgeries and various other invasive procedures are needed for combat-trauma cases.

Joint Procurement.—Despite other examples of joint procurements of magnetic resonance imaging equipment, the recent major capital medical equipment acquisitions by DoD in Fayetteville at Womack Army Medical Center and El Paso at William Beaumont Army Medical Center were made without consultation or coordination with nearby or co-located VA facilities. Such independent decisions affect these facilities' relationships for many years after the

fact, add unnecessary cost, create inefficiency and contribute to further counterproductive decisions in both facilities. These were clearly lost opportunities for joint procurement. In addition to medical equipment, numerous opportunities exist for joint procurement of pharmaceuticals, medical supplies and contracted medical care and support services.

RECOMMENDATION

With the Administration's broad scale defense reviews, reinforced by the terrorist attacks of September 11, 2001, DoD appears to be entering a period of reassessment of its basic military assumptions. This should affect DoD's health policy decisions, as well as facility management and other elements of its health care administration. With its Capital Asset Realignment for Enhanced Services initiative, the VA is also studying the realignment of its health care capital assets. The Committee on Veterans' Affairs staff concludes that as the two departments move ahead, many of the observed organizational barriers and redundancies could be reduced or eliminated, and new incentives could be created to help achieve greater sharing of their health resources.

Demonstration Projects.—The barriers the Committee on Veterans' Affairs, GAO and the Transition Commission identified have reduced the ability of VA and DoD to maximize efficiencies and the quality of patient care that Congress intended for their health care programs. To improve the effectiveness of the existing joint ventures VA and DoD should undertake demonstration projects to:

- Develop and implement integrated and compatible budgets, reimbursement methodologies, cost accounting systems and information technology systems; additionally, develop a budgeting and resource allocation process that takes into account the combined needs of the two departments at each joint venture location, including a demonstration "unified budget," to be presented jointly to Congress by the two Secretaries.
- Create an information infrastructure that facilitates data exchange of patient health, financial and management information across the demonstration sites.
- Consolidate the employment and human resources management authorities of title 10 and title 38 of the U.S. Code; use the new flexibility to develop a hybrid system that incorporates the best of both systems.
- Develop a joint policy staff to identify needs based upon the combined VA-DoD beneficiary population in conjunction with each department's missions; this policy staff should develop a joint strategic plan to accomplish these missions, including identifying opportunities for capital infrastructure projects and joint procurement of equipment, supplies and services.
- Establish a new federal facility in Charleston, SC, that consolidates the Charleston Naval Hospital, the Johnson VA Medical Center and the Medical University of South Carolina academic health center.

- Consolidate VA health care at Womack Army Medical Center, Fayetteville, NC; build a new VA ambulatory and long-term care facility that adjoins Womack.
- Develop a joint patient medical record and combine the Government Computerized Patient Record initiative with VA's Computerized Patient Record System and DoD's Composite Health Care System.
- Develop a "certificate of need"-type requirement for any VA or DoD capital medical acquisition investment or new infrastructure requirements in the 21 co-located VA-DoD facility sites identified by GAO.

Additionally, VA and DoD should mandate a specific savings goal, such as a quantified level of savings over five years based on their combined medical outlays nationwide. The departments should prepare and submit a joint report of such savings achieved through resource sharing initiatives. The departments should also submit an acquisition plan specifying the medical equipment, supplies, clinical services and support services to be jointly procured.

Congress should consider legislation to achieve improved access, readiness enhancement and greater efficiencies in this major health investment by the American people. On July 27, 2001, the Chairman of the Committee on Veterans' Affairs introduced H.R. 2667, the Department of Defense-Department of Veterans Affairs Health Resources Access Improvement Act of 2001.[2]

The bill would:

1. Establish findings of Congress that, after nearly two decades of legislative authority, Department of Veterans Affairs (VA) and Department of Defense (DoD) sharing of health resources is inadequate given the still unfulfilled potential of two independent appropriated Federal health care providers to work together; and the sense of Congress that the departments should explore new ways to improve health resource sharing.
2. Establish a health care facilities integration demonstration project, with five qualifying sites selected jointly by the Secretaries of Veterans Affairs and Defense, to identify advantages and challenges of integrating co-located military and VA health care facilities.
3. Require a unified management system be adopted in the qualified demonstration sites, including budget and financial management; health care staffing and assignment; and, medical information and information technology systems that provide standards of information quality equivalent to those adopted for the departments at large.
4. Empower each Secretary to waive regulations and administrative policies that impede the purposes of the demonstration project with a report of requested waivers and dispositions of requests.
5. Authorize the Secretary of Defense to appoint, using authorities available to the Secretary of Veterans Affairs, under Chapter 74 of Title 38, United States Code, civilian health

[2] See Appendix II for text of bill.

care personnel to duties in facilities unified under the demonstration project.

6. Authorize, to the extent practicable, the same health benefit and co-payment rates for VA and Defense beneficiaries in facilities participating in the demonstration project; prohibit reductions in existing benefit levels or increases in co-payment rates applicable to any patient under care in a unified facility under the demonstration project.
7. Authorize to be appropriated to each department, $10 million for fiscal year 2002 and $25 million for each succeeding year, during the term of the demonstration project, to be used to establish the demonstration project and underwrite further enhancements to VA-DoD sharing.
8. Require the Secretaries of VA and Defense to submit within two years a joint prospectus for construction of a new, more accessible and unified Federal health care facility in an area where co-located VA and DoD facilities need replacement.
9. Require that both Secretaries study, develop, and implement shared affiliation agreements for graduate medical education at demonstration project sites.
10. Require the Secretaries to share health resources when such sharing is feasible and consistent with national policy.
11. Rescind requirement that VA maintain a maximum number of authorized, and a minimum number of operating, hospital and nursing home beds in conjunction with VA-DoD military contingency support.
12. Require Secretaries to submit a final report eight months prior to termination of the demonstration project, and terminate demonstration project on September 30, 2006.

H.R. 2667 will be included in the legislative agenda of the Committee on Veterans' Affairs for consideration during the second session of the 107th Congress.

APPENDIX I

SITE VISITS and CONTACTS

Greater Los Angeles VA Healthcare System, West Los Angeles, CA, February 20, 2001.

Kenneth Clark, Director VA Desert Pacific Healthcare Network
Ronald Norby, Deputy Network Director/Clinical Services Officer VISN 22
Philip P. Thomas, Chief Executive Officer, GLA
Charles Dorman, Chief Operating Officer, GLA
Dr. Dean Norman, Chief of Staff, GLA
Dr. Erika Scremmin, Chief of Physical Medicine/Rehabilitation, GLA
Dr. Phillis Guze, Chief of Medicine, GLA
Dr. Robert Eli, Vice President for Mental Health, GLA
Steve Berman, Chief of Community-Based Services, GLA
Lynn Carrier, Vice President for Administration and Support Services, GLA
Donna Bieter, Vice President for Clinical Support Services and Nurse Executive, GLA
Gloria Martinez, Vice President for Ambulatory and Primary Care, GLA
Dr. Michael Mahler, Vice President for Specialty and Hospital-Based Services, GLA

VA San Diego Healthcare System and *Balboa Naval Medical Center*, San Diego, CA, February 21, 2001.

Ronald Norby, Deputy Network Director, VA Desert Pacific Healthcare Network
Gary Rossio, CEO, VASDHS
Jacqueline G. Parthemore, MD, Chief of Staff, VASDHS
Janet Jones, RN ACOS/Nursing and Patient Care Services, VASDHS
Sarah Simpkins, DDS, VISN 22/DoD Coordinator
Robert Stevens, Administrative Coordinator, External Sites, VASDHS
Cindy Butler, Public Affairs Officer, VASDHS
Capt. Kristine Minnick, Director, TRICARE Southern California, Region 9
Capt. William Roberts, Deputy Commander, Naval Medical Center, San Diego
Capt. Elaine Melissa Kaime, Breast Health Center
Capt. Rick Cole, Nuclear Medicine
Cmdr. Muying Dow, Pharmacy
Douglas Sayers, Public Affairs Officer, Naval Medical Center, San Diego
Dr. Ron Jackson, Civilian Scientist, Defense Spatial Orientation Center

Mike O'Callaghan Federal Hospital, Las Vegas, NV, February 22, 2001.

Ron Norby, Deputy Director, VA Desert Pacific Healthcare Network
John Hempel, CEO, VA Southern Nevada Healthcare System
Sharon Joseph, Acting Chief Operations Officer, VASNHS
Anthony Salem, Chief of Staff, VASNHS
Dan Gerrard, Chief Administrative Officer MOFH
Col. Philip La Kier, 99th Medical Group Commander, CEO MOFH
Col. John Butler, Deputy Commander 99th Medical Group
Col. Stephen Schmidt, Commander, Dental Squadron
Col. Mary Moran, Commander, Medical Operations Squadron
Lt. Col. Evelyn Otero-Ruiz, Operations Officer, Medical Operations Squadron
Lt. Col. Danny Seanger, Commander, Medical Support Squadron
Lt. Col. Verba Moore, Commander, Aerospace Medicine Squadron

New Mexico VA Health Care System and *VA Medical Center–Kirtland AFB*, Albuquerque, NM, February 23, 2001.

Arlene Martin, AF Joint Venture Assistant Director
Smith Jenkins, VISN 18 Director, NMVASCS
Patricia A. McKlem, Interim Chief Executive Officer, NMVAHCS
Barbara K. Chang, M.D., M.A., Chief Medical Officer, NMVAHCS
Ron Richter, Chief, Engineering, Acting Chief Operating Officer, NMVAHCS
Cynthia Nuttall, R.N., Medical Staff Coordinator, NMVAHCS
Catherine Beesley, Joint Venture Director, Management Analyst, CMO, NMVAHCS
Col. Marconi-Dooley, Medical Group Commander
Col. Byers, Medical Group Deputy Commander
Col. Williams, Chief of Professional Services
Maj. Pascoe, Support Squadron Commander

First Naval Hospital and *Ralph H. Johnston, VAMC*, Charleston, SC, April 11, 2001.

Capt. Alana Benton, Commanding Officer
Capt. Ken Meredith, Executive Officer
Robert A. Perreault, Director
Tony Bennett, Chief Financial Officer
Larry Labbate, Physician, Mental Health Service
Patti Snodgrass, Chief Resident, Mental Health Service
T. Lynn McFall, Chief, Physical Medicine and Rehab Service
Philip Freedland, Chief, Radiology Service
Sarah D. Williams, Associate Nurse Executive
Denise R. Carey, Associate Medical Center Director for Patient Care Services
Avtar K. Singh, Chief, Path-Lab Medicine Service
William R. Tyor, Chief, Neurology Service
Bernard G. Williams, Chief, Dental Service
Nancy G. Mikell, Chief, Pharmacy Service

Diane Milligan, Coordinator, Surgical Service
Dexter Hood, Health Administration Officer
Lt. Cmdr. Jeff Plummer, Legislative Liaison–SECNAV

Brooke Army Medical Center, San Antonio, TX, April 17, 2001.

Maj. Gen. Lee P. Rodgers, CG Wilford Hall Medical Center
Brig. Gen. Daniel Perugini, Commander, GPRMC and BAMC
Col. Glenn Taplin, Chief of Staff, GPRMC
Col. Greg Anders, Medical Director, GPRMC
Maj. Tim Edmon, Director of Managed Care, GPRMC
Rosa Wages, Health Systems Specialist, GPRMC
Col. Maryann McAfee, Acting Deputy Commander for Clinical Services, BAMC
Col. Martin Fisher, Deputy Commander for Administration, BAMC
Lt. Col. Carlos Angueira, Dept of Health Plans Management, BAMC
Joe Heer, Management Analyst, BAMC
Col. Thomas Peters, Administrator, WHMC
Col. Philip J. Perucca, Chief of the Medical Staff, WHMC
Lt. Col. Donna Wallace, Plan/Program Analysis, WHMC
Sandra Berrigan, Associate Director for Patient Care, VA
Louise Parker, Assistant to the Chief of Staff, VA

VA El Paso Health Care System and *William Beaumont Army Medical Center*, El Paso, TX, April 18, 2001.

Byron K. Jaqua, CEO, El Paso VA Health Care System
Dr. Stephen Shapiro, Chief Medical Officer, El Paso VA Health Care System
Everett Ray Perdue, Special Assistant to the CEO
Brenda James, Chief Coordinated Care and Social Work Service
Albert Hernandez, Administrative Officer to the CMO
Col. Carla G. Hawley-Bowland, Commander, BAMC
Col. Homer J. Lemar, Acting Deputy Commander for Clinical Services, BAMC
Col. Iris West, Acting Deputy Commander for Patient Services/Nursing, BAMC
Lt. Col. Leo F. Voepel, Escort Officer, Business Management Division, BAMC
Lt. Col. Al W. Moran, Chief, Business Management Division, BAMC
Maj. Mark C. Wilhite, Acting Chief of Staff, BAMC
Laverne A. Rupkalvis, Business Management Division, BAMC

Fayetteville VA Medical Center and *Womack Army Medical Center*, Fayetteville, NC, May 10–11, 2001.

Daniel Hoffman, Director, VISN 6
Janet Stout, Medical Center Director FVAMC
James Skidmore, Director for Operations FVAMC
Lynn Cooper, RN, Director Patient Care Services FVAMC
Alan Shernoff, DDS, Acting Chief of Staff FVAMC
Joseph Albanese, Chief, Business Office FVAMC
Thomas Hallum, Staff Assistant to the Director FVAMC

Eugene Paul, Minority Veteran/Homeless Coordinator FVAMC
Paul Reid, AFGE Local 2080 President
Norma Byrd, Public Affairs Officer FVAMC
Bonnie Henderson, VBA Regional Office, Winston-Salem
Gerald York, VA Regional Office, Winston-Salem, NC
Col. Matteson, WAMC Commander
Col. Ray Terrill, WAMC Chief of Staff
Lt. Col. Brian Canfield, WAMC Chief Directorate of Business Operations
Lt. Col. John Lee, WAMC Executive Officer
Maj. David Petray, WAMC Chief Resource Management Division
Jan Delaney, WAMC Management Analyst
Chuck Burden, WAMC Chief Clinical Operations Division
Shannon Speight–Lynch, WAMC Public Affairs Officer

North Chicago VA Medical Center, Chicago, IL, June 8, 2001.

Patrick Sullivan, Acting Director
Tariq Hassan, MD, Chief of Staff
Mary Roseborough, MSN, Associate Director for Patient Services/Nurse Executive
Frank Maldonado, MD, Chief of Medicine
Darryl Holst, Leader, Facility Management
Chuck Loring, Facility Management
Terry Martin, Administrative Assistant to the Chief of Staff
Doug Shouse, Staff Asst. to the Director
Kathryn Maginnis, Coordinator for CARES, VAHQ Staff
Jack Hetrick, Deputy VISN Director (at North Chicago VAMC meeting)
Larry Wilson, HSS for VISN 12 (at Great Lakes Naval Hospital meeting)

Naval Hospital Great Lakes, Great Lakes, IL, June 8, 2001.

Capt. Elaine C. Holmes, MC, Commanding Officer
Capt. Raymond J. Swisher, MSC, Executive Officer
Capt. Mathew Ausmus, DC, Director of Surgical Services (Acting)
Capt. Deborah Gray, NC, Director of Nursing Services
Cmdr. Andrea Rosemond, NC, Director of Fleet Medicine (Acting)
Cmdr. Deborah Mathews, NC, Head Quality Assurance (Acting)
Cmdr. Joel Cook, MC, Director of Ancillary Services
Cmdr. Martie Slaughter, MSC, Director for Administration
Lt. Cmdr. Sharon Moser, MSC, Director of Resources Management
Lt. Cmdr. Jennifer Anders, MC, Director of Primary Care (Acting)
Lt. James Stilley, MSC, Head of Managed Care Department (Acting)
Lt. Roland Fahie, MSC, Head of Blood Banking Services Division
Lt. Thomas Matt, MSC, Assistant Director of Resources Management

Lt. Jeff Paul, MSC, Head of Personnel Department
Lt. j.g. Sophie Alexander, MSC, Utilization Review Division
Master Chief Petty Officer Richard Kough, Command Master Chief
Petty Officer 1st Class Sam Collins, Plans/Operations/Medical Intelligence

VA-DoD Resource Sharing Meeting, Washington, D.C., June 27, 2001.

Maj. Gen. Hal Timboe, Medical Corps, Commanding General, North Atlantic Regional Medical Command and Walter Reed Army Medical Center
Rear Adm. K. Martin, Commander, NNMC, Bethesda
Patrick Ryan, Staff Director, HVAC
Art Wu, Deputy Staff Director, HVAC
John Bradley, Staff Director for Health, HVAC
Veronica Crowe, Professional Staff Member, HVAC
Len Sistek, Minority, Oversight and Investigation, HVAC
Susan Edgerton, Minority Staff Director for Health, HVAC
Debra Wada, Minority Professional Staff Member, HASC
Ed Wyatt, Professional Staff Member, HASC
Rebecca Hyder, Legislative Director, Rep. Bilirakis
Art Hamerschlag, Deputy Chief Financial Officer, VHA
Sheila McCready, VHA
Sandy Garfunkel, Director, VAMC, Washington, D.C.
Earl Newsome, VAMC, Washington, D.C.
Edward Demarest, VA–ADOSH
Doug Dembling, VA–OCLA
Ann C. Barr, GAO
Lt. Col. James Grier, Army OCLL
Lt. Cmdr. Jeff Plummer, Navy–OCLL

APPENDIX II

H.R. 2667, DEPARTMENT OF DEFENSE–DEPARTMENT OF VETERANS AFFAIRS HEALTH RESOURCES ACCESS IMPROVEMENT ACT OF 2001

I

107TH CONGRESS
1ST SESSION

H. R. 2667

To provide for a joint Department of Defense and Department of Veterans Affairs demonstration project to identify benefits of integrated management of health care resources of those departments, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JULY 27, 2001

Mr. SMITH of New Jersey (for himself, Mr. BILIRAKIS, Mr. EVERETT, Mr. BUYER, Mr. GIBBONS, Mr. SIMMONS, Mr. BROWN of South Carolina, Mr. WAMP, and Mr. KIRK) introduced the following bill; which was referred to the Committee on Veterans' Affairs, and in addition to the Committee on Armed Services, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To provide for a joint Department of Defense and Department of Veterans Affairs demonstration project to identify benefits of integrated management of health care resources of those departments, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

1 **SECTION 1. SHORT TITLE.**

2 This Act may be cited as the "Department of De-
3 fense-Department of Veterans Affairs Health Resources
4 Access Improvement Act of 2001".

5 **SEC. 2. FINDINGS AND SENSE OF CONGRESS CONCERNING**
6 **STATUS OF HEALTH RESOURCES SHARING**
7 **BETWEEN THE DEPARTMENT OF VETERANS**
8 **AFFAIRS AND THE DEPARTMENT OF DE-**
9 **FENSE.**

10 (a) FINDINGS.—Congress makes the following find-
11 ings:

12 (1) Federal health resources provided by the
13 people of the United States through tax receipts are
14 by their nature scarce and thus should be effectively
15 and efficiently used.

16 (2) In 1982, Congress authorized health re-
17 sources sharing between Department of Defense
18 medical treatment facilities and Department of Vet-
19 erans Affairs health care facilities in order to allow
20 more effective and efficient use of their health re-
21 sources.

22 (3) Health care beneficiaries of the Depart-
23 ments of Defense and Veterans Affairs, whether ac-
24 tive servicemembers, veterans, retirees, or family
25 members of active or retired servicemembers, should

1 have full access to the health care and services that
2 Congress has authorized for them.
3 (4) The Secretary of Defense and the Secretary
4 of Veterans Affairs, and the appropriate officials of
5 each of those departments with responsibilities relat-
6 ed to health care, have not taken full advantage of
7 the opportunities provided by law to make their re-
8 spective health resources available to health care
9 beneficiaries of the other department in order to
10 provide improved health care for the whole number
11 of beneficiaries.
12 (5) After the many years of support and en-
13 couragement from Congress, the departments have
14 made little progress in health resource sharing and
15 the intended results of the sharing authority have
16 not been achieved.
17 (b) SENSE OF CONGRESS.—Congress urges the Sec-
18 retary of Defense and the Secretary of Veterans Affairs
19 to commit their respective departments to exploring new
20 ways for significantly improving health resources sharing
21 and to building organizational cultures supportive of
22 health resources sharing.
23 (c) PURPOSE.—It is the purpose of this Act—
24 (1) to authorize a demonstration program to
25 advance the principles of health resources sharing

consistent with the expressed intent of Congress; and

(2) to establish a basis for joint strategic planning of Department of Defense and Department of Veterans Affairs health systems to ensure that available funds are used more effectively and efficiently in order to enhance access to high quality health care for their beneficiaries.

SEC. 3. HEALTH CARE FACILITIES INTEGRATION DEMONSTRATION PROJECT.

(a) ESTABLISHMENT.—The Secretary of Veterans Affairs and the Secretary of Defense shall conduct a demonstration project to identify advantages of providing for integrated management of military treatment facilities and VA health care facilities that are located in the same geographic area.

(b) SITE IDENTIFICATION.—(1) The Secretaries shall jointly identify five qualifying sites at which to conduct the demonstration project under this section.

(2) For purposes of this section, a qualifying site is an area in the United States in which—

(A) one or more military treatment facilities and one or more VA health care facilities are situated in relative proximity to each other;

1 (B) for which there could be in effect within
2 one year after the date of the enactment of this Act
3 an integrated budget and personnel system for those
4 facilities; and
5 (C) as determined by the Secretaries, both the
6 candidate VA facilities and the candidate military
7 medical treatment facilities have in place informa-
8 tion systems to demonstrate the validity of the ac-
9 tivities of those facilities so that the Secretaries are
10 confident that they will be able to effectively meas-
11 ure differences in activities at those facilities (includ-
12 ing cost, access, quality, patient satisfaction, and
13 other important performance indicators) before the
14 demonstration project, during the period of the dem-
15 onstration project, and after the end of the dem-
16 onstration project.
17 (c) CONDUCT OF DEMONSTRATION PROJECT.—At
18 each site at which the demonstration project is conducted,
19 the Secretaries shall provide for a unified management
20 system for the military treatment facilities and VA health
21 care facilities at that site. To the extent feasible, that uni-
22 fied management system shall include—
23 (1) a unified budget and financial management
24 system for those facilities;

1 (2) a unified staffing and assignment system
2 for the personnel employed at or assigned to those
3 facilities; and
4 (3) medical information and information tech-
5 nology systems for those facilities that—
6 (A) are unified across those facilities;
7 (B) maintain interoperability with medical
8 information and information technology systems
9 of the respective departments of those facilities;
10 and
11 (C) incorporate standards of information
12 quality that are at least equivalent to those
13 adopted for the departments at large.
14 (d) AUTHORITY TO WAIVE CERTAIN ADMINISTRA-
15 TIVE REGULATIONS AND POLICIES.—(1) In order to carry
16 out subsection (c), the Secretary of Defense may, in the
17 Secretary's discretion, waive any regulation or administra-
18 tive policy otherwise applicable to the Department of De-
19 fense, and the Secretary of Veterans Affairs may, in the
20 Secretary's discretion, waive any regulation or administra-
21 tive policy otherwise applicable to the Department of Vet-
22 erans Affairs, as each Secretary determines necessary for
23 the purposes of the demonstration project.
24 (2) Not later than one year after the date of the en-
25 actment of this Act, the Secretary of Veterans Affairs and

1 the Secretary of Defense shall jointly submit to the Com-
2 mittees on Veterans' Affairs and the Committees on
3 Armed Services of the Senate and House of Representa-
4 tives a report on the use of the authority provided by para-
5 graph (1). The report shall include a statement of the
6 numbers and types of requests for waivers of regulations
7 and administrative policies that have been made to that
8 date and the disposition of each.

9 (e) USE OF TITLE 38 PERSONNEL AUTHORITIES.—
10 (1) In order to carry out subsection (c), the Secretary of
11 Defense may apply to civilian personnel of the Department
12 of Defense assigned to or employed at a military treatment
13 facility participating in the demonstration project any of
14 the provisions of subchapters I, III, and IV of chapter 74
15 of title 38, United States Code, determined appropriate
16 by the Secretary.

17 (2) For such purposes, any reference in such
18 chapter—

19 (A) to the "Secretary" or the "Under Secretary
20 for Health" shall be treated as referring to the Sec-
21 retary of Defense; and

22 (B) to the "Veterans Health Administration"
23 shall be treated as referring to the Department of
24 Defense.

1 (f) FACILITIES TO BE DEEMED FACILITIES OF THE
2 OTHER DEPARTMENT.—A VA health care facility partici-
3 pating in the demonstration project shall be considered to
4 be a military treatment facility for purposes of eligibility
5 for care for beneficiaries of the Department of Defense,
6 and a military treatment facility participating in the dem-
7 onstration project shall be considered to be a VA health
8 care facility for purposes of eligibility for care for bene-
9 ficiaries of the Department of Veterans Affairs.
10 (g) BENEFITS, COPAYMENTS, ETC., TO BE EQUAL-
11 IZED.—In the case of facilities of the participating depart-
12 ments selected to participate in the demonstration project,
13 the medical care for which a beneficiary of the Department
14 of Defense or beneficiary of the Department of Veterans
15 Affairs is eligible, and any required copayments or
16 deductibles for such care applicable to the beneficiaries of
17 either participating department, shall to the extent prac-
18 ticable be the same. Regulations to govern such benefits,
19 copayments, and deductibles shall be prescribed by the
20 Secretary of Defense and the Secretary of Veterans Af-
21 fairs. However, in no case may the benefits for which any
22 beneficiary is eligible be reduced or any copayment or de-
23 ductible applicable to any beneficiary be increased.

1 (h) AUTHORIZATION OF APPROPRIATIONS.—There is
2 authorized to be appropriated to each of the participating
3 departments to carry out the demonstration project—
4 (1) $10,000,000 for fiscal year 2002; and
5 (2) $25,000,000 for each succeeding year dur-
6 ing which the demonstration project is in effect.
7 (i) DEFINITIONS.—For purposes of this section:
8 (1) The term "military treatment facility"
9 means a medical facility under the jurisdiction of the
10 Secretary of a military department.
11 (2) The term "VA health care facility" means
12 a facility under the jurisdiction of the Veterans
13 Health Administration of the Department of Veter-
14 ans Affairs.
15 (3) The term "participating departments"
16 means the Department of Veterans Affairs and the
17 Department of Defense.
18 (j) TERMINATION.—The demonstration project, and
19 the authority provided by this section, shall terminate on
20 September 30, 2006.

21 **SEC. 4. JOINT PROSPECTUS FOR CONSTRUCTION OF NEW**
22 **MEDICAL FACILITY.**

23 Not later than two years after the date of the enact-
24 ment of this Act, the Secretary of Defense and the Sec-
25 retary of Veterans Affairs shall submit to the appropriate

1 committees of Congress a prospectus for construction of
2 a new joint medical facility for their respective depart-
3 ments. The location for the new joint facility shall be se-
4 lected jointly by the two Secretaries and shall be—
5 (1) at a location where both a current Depart-
6 ment of Veterans Affairs medical center and a cur-
7 rent Department of Defense military treatment facil-
8 ity are in need of replacement and the new facility
9 can be a replacement for both; or
10 (B) situated so as to provide improved access to
11 eligible veterans and eligible military beneficiaries in
12 a location where there is only one Department of
13 Veterans Affairs medical center or military medical
14 treatment facility serving one of those beneficiary
15 populations.
16 **SEC. 5. GRADUATE MEDICAL EDUCATION.**
17 (a) FINDINGS.—Congress finds that integration or
18 consolidation of graduate medical education programs of
19 the Department of Defense and Department of Veterans
20 Affairs would—
21 (1) lead to increased efficiencies by eliminating
22 duplicative administrative processes and streamlin-
23 ing and consolidating joint training programs;

1 (2) allow increased clinical training sites in De-
2 partment of Defense and Department of Veterans
3 Affairs accredited programs; and
4 (3) make Department of Veterans Affairs facili-
5 ties available to military reserve health care profes-
6 sionals education programs.
7 (b) COMPREHENSIVE REVIEW.—The Secretary of
8 Defense and the Secretary of Veterans Affairs shall enter
9 into a joint contract for the conduct by an organization
10 outside the Government of an independent, comprehensive
11 review to identify opportunities for joint funding for an
12 integrated graduate medical education program at facili-
13 ties of their respective departments where such an inte-
14 grated program is feasible.
15 (c) FUNDING.—Funds for the contract under sub-
16 section (b) shall be provided in equal shares by the De-
17 partment of Defense and the Department of Veterans Af-
18 fairs.
19 (d) COMMON AFFILIATION AGREEMENT.—Based on
20 the results of the review under subsection (b), the Sec-
21 retary of Defense and the Secretary of Veterans Affairs
22 shall develop and implement a common affiliation agree-
23 ment or contract for graduate medical education purposes
24 at locations where the demonstration project under section
25 3 is carried out.

1 **SEC. 6. REQUIRED SHARING OF HEALTH CARE RESOURCES.**

2 (a) REQUIRED SHARING.—Section 8111(a) of title
3 38, United States Code, is amended by striking "may
4 enter into" and inserting "shall enter into".

5 (b) CONFORMING AMENDMENT.—Section 1104 of
6 title 10, United States Code, is amended by striking
7 "may" and inserting "shall".

8 (c) REPEAL OF VA BED LIMITS.—(1) Section
9 8110(a)(1) of title 38, United States Code, is amended—

10 (A) in the first sentence, by striking "at not
11 more than 125,000 and not less than 100,000";

12 (B) in the third sentence, by striking "shall op-
13 erate and maintain a total of not less than 90,000
14 hospital beds and nursing home beds and"; and

15 (C) in the fourth sentence, by striking "to en-
16 able the Department to operate and maintain a total
17 of not less than 90,000 hospital and nursing home
18 beds in accordance with this paragraph and".

19 (2) Section 8111(a) of such title is amended by strik-
20 ing ", except that" and all that follows through "of the
21 Government" before the period at the end.

22 **SEC. 7. REPORTS.**

23 (a) INTERIM REPORT.—Not later than February 1,
24 2003, the Secretary of Defense and Secretary of Veterans
25 Affairs shall submit to the Committees on Veterans' Af-
26 fairs and the Committees on Armed Services of the Senate

1 and House of Representatives a joint interim report on
2 the conduct of programs under this Act through the end
3 of the preceding fiscal year. The Secretaries shall include
4 in the report a description of the measures taken, or
5 planned to be taken, to implement the demonstration
6 project under section 3 and the other provisions of this
7 Act and any cost savings anticipated at facilities partici-
8 pating in the demonstration project.

9 (b) FINAL REPORT.—Not later than February 1,
10 2006, the Secretary of Defense and Secretary of Veterans
11 Affairs shall submit to the committees of Congress speci-
12 fied in subsection (a) a joint report on the conduct of pro-
13 grams under this Act through the end of the preceding
14 fiscal year. The Secretaries shall include in the report the
15 following:

16 (1) A description of activities under this Act.

17 (2) Identification of cost savings, access im-
18 provements, and other efficiencies realized under the
19 demonstration project carried out under section 3.

20 (3) Analysis of measurable changes achieved by
21 the demonstration project, including the use of data
22 sources and performance indicators described in sec-
23 tion 3(b)(2)(C).

24 (4) Transmittal of the report resulting from the
25 review required by section 5(b), accompanied by ap-

1 propriate recommendations by the Under Secretary
2 of Veterans Affairs for Health and the Assistant
3 Secretary of Defense for Health Affairs.
4 (5) Any recommendations of the two Secretar-
5 ies for expansion of the demonstration project to ad-
6 ditional facilities or for modification to any of the
7 authorities for the demonstration project provided in
8 section 3.

QUESTIONS AND ANSWERS SUBMITTED FOR THE RECORD

MARCH 7, 2002

QUESTIONS SUBMITTED BY DR. SNYDER

Dr. SNYDER. Dr. Mackay, TRICARE has established access standards for its beneficiaries. For example, TRICARE requires that an appointment for urgent care not exceed 24 hours, routine care not exceed 7 days, and referred, specialty, or preventive care not exceed 30 days. In addition, it requires that beneficiaries wait time in an office should not be more than 30 minutes. Military treatment facilities and TRICARE Prime civilian providers must meet these TRICARE standards. Does VA have similar standards? If so, what are the standards for access to care? If not, would you expect the VA to be able to meet the TRICARE access standards at participants in joint DOD/VA sharing arrangements?

Dr. MACKAY. The bulk of VHA appointments are for the management of chronic stable medical conditions. Urgent care patients or unstable patients are triaged and seen within a time period that is consistent with their medical condition and medical necessity for more immediate treatment. For urgent care patients, the expectation is that the patient will be seen within 24 hours or less.

VHA waiting time targets were presented in the Department's FY 2003 budget submission as follows:

- Clinic Waiting Time Performance Plan Goal:
- Measure: Percent of primary care appointments scheduled within 30 days of desired date.
- Target FY 2002: 88%
- Target FY 2003: 88.5%
- Measure: Percent of specialty care appointment scheduled within 30 days of desired date.
- Target FY 2002: 85%
- Target FY 2003: 86.5%
- Provider Waiting Time Performance Plan Goal:
- Measure: Percent of patients who report being seen within 20 minutes of the scheduled appointment time.
- Target FY 2002: 70%
- Target FY 2003: 72%
- By September 30, 2002, the average waiting time will decrease for the following clinics: Eye care, audiology, orthopedics, cardiology, urology, and Primary Care will be equal to or less than 30 days.

Dr. SNYDER. Dr. Mackay, most of the VA hospitals are already participating providers in TRICARE, but are not seeing a great number of DOD beneficiaries. In addition, many military families would prefer to go to one facility that can treat the whole family. Since VA can only treat the service member, how would you address these concerns?

Dr. MACKAY. Some VA medical centers, e.g. Jackson, MS, and Palo Alto, CA, have established separate clinics for TRICARE beneficiaries. These clinics are available for family members provided the VA medical center has the resources available to provide treatment. However, no VA medical center has the resources or necessary expertise, e.g. pediatrics, to give complete care to family members. VA does have the contract authority to provide appropriate services to family members but it has not been cost effective to do so. One barrier to VA providing complete care to family members is the increased utilization of VA medical centers by veterans. The number of users of the VA medical system increased from 3,476,991 in Fiscal Year 1999 to 4,149,706 in Fiscal Year 2001.

Dr. SNYDER. Dr. Mackay, currently VA will only fill a prescription that is provided by a VA doctor. DOD, on the other hand, allows beneficiaries to use military treatment facilities and network and non-network retail pharmacies. Given the number of VA facilities across the country, it may be cost effective to the Federal Government and provide greater access to military beneficiaries to have VA facilities fill prescriptions for DOD families. Do you believe that the VA pharmacies have the capacity to meet this requirement? VA could also use DOD'S network of pharmacies to expand access for veterans. Is this something that is under consideration by the VA/DOD Health Executive Council?

Dr. MACKAY. For over 12 years, VA has actively supported the concept of filling prescriptions for DOD families and is willing to do so. To accomplish this, the two Departments are actively pursuing an electronic interface to enable a pilot test of dispensing refill prescriptions from DOD Medical Treatment Facilities (MTFs) via VA's Consolidated Mail Outpatient Pharmacy (CMOP) program. The pilot test of the interface is planned for late summer of 2002. Given VA's current capabilities, additional CMOP capacity to dispense DOD refill prescriptions (estimated to be between 25 and 30 million annually) will be required.

The idea of utilizing DOD's network of retail pharmacies as a mechanism to improve access for veterans has waned since the early 1990s as a result of VA's highly efficient CMOP program. In fact, DOD officials are very interested in lowering their beneficiary's use of the retail network to lower costs associated with filling prescriptions; thus, Dodd is interested in partnering with VA to process prescriptions through the CMOP program. As indicated above, additional capacity is required to process DOD refill prescriptions through the CMOP program. Assuming the pilot test is successful and evaluated by DOD to be a sound business practice, DOD officials have indicated they would undertake a significant effort to reduce the number of their prescriptions dispensed from the existing retail network.

Dr. SNYDER. Dr. Mackay, one of the concerns raised has been the inability of DOD and VA to exchange medical and financial information. For the past several years, VA and DOD have been working on developing a Government Computer-Based Patient Record (GCPR) for each service member. The idea was that each service member would have his or her own computerized patient record that would follow him or her throughout their career in the military and then be transferred or provided to VA following their departure from the service. Where are we on GCPR? Is VA able to access the entire medical record of a service member today? If not, when do you think the program will be completed so that the complete medical record of a service member will be online and accessible to authorized users?

Dr. MACKAY. Software engineering and development of the GCPR Near Term Solution (NTS) is complete. Alpha testing at the VA Medical Center San Diego, California, was completed in December 2001 and Beta testing began in January 2002. Following the successful completion of the Beta testing and evaluation in the third quarter of FY 2002, enterprise-wide deployment of the NTS within VA is anticipated to begin in the third quarter of FY 2002.

Dr. SNYDER. Is VA able to access the entire medical record of a service member today?

Dr. MACKAY. No. However, NTS will enable VA clinicians to access significant amounts of health information on service members who have separated or retired. DOD has extracted approximately 3.75 million patient records, from CHCS I systems in all MTFs, and transferred them to the VA. This data will be available electronically to VA clinicians in a manner similar to VA patient data in any of the VA medical center sites. These electronic records currently contain information generally acknowledged to be most important for assessment and treatment, including patient demographics, outpatient pharmacy, radiology, chemistry, microbiology, and surgical pathology reports.

Dr. SNYDER. If not, when do you think the program will be completed so that the complete medical record of a service member will be online and accessible to authorized users?

Dr. MACKAY. VA and DOD have plans for a Federal Health Information Exchange (FHIE)/GCPR Mid Term Solution. By FY 2004 all electronic information in CHCS I on separated service members (up to the time of their separation) will be available electronically to authorized VA users. For recently separated service members, the information should become available within 2 months of the date of their separation.

Dr. SNYDER. If VA is to [increase] its participation in the TRICARE program, will part of the participation include the ability to access medical data for active duty personnel to provide treatment?

Dr. MACKAY. For any patient seen by VA as part of a TRICARE arrangement, including active duty personnel, it would be important to have access to relevant medical data. One option would be to use the FHIE (formerly the Government Computer-Based Patient Record) effort, already in testing as of the end of calendar year 2001.

Dr. SNYDER. Dr. Chu, are there currently any incentives for TRICARE providers, both the military treatment facilities and the TRICARE managed care contractors, to engage in resource sharing activities with the VA? Should there be more incentives and, if so, what kinds of incentives will help to ensure that such sharing agreements not just reduce spending, but increase services to beneficiaries as well?

Dr. CHU. We are working to strengthen these incentives. As I have pointed out, my near terms goals include establishing solid business procedures for reimburse-

ment of services and improving access to health care through VA participation in TRICARE. Both departments must ensure that we have the right resources and leadership in place to make this happen.

Dr. SNYDER. Dr. Chu, military families are deeply concerned about the lack of uniformity of health care services across the TRICARE system. How do we ensure that DOD/VA resource sharing activities in specific sites do not result in additional inequities among the TRICARE regions and overseas?

Dr. CHU. Concerns about the lack of uniformity of health care services have not surfaced during my discussions with military families. In fact, beneficiaries express very high levels of satisfaction with TRICARE. Availability of services does vary from one military facility to another, owing to differing capacity and capabilities. The civilian component of TRICARE — the TRICARE provider networks — fill in any gaps left by the lack of service availability in military facilities. DOD/VA sharing can augment TRICARE capabilities and increase efficiencies, and thus further enhance beneficiary satisfaction.

Dr. SNYDER. Dr. Chu, many of the VA facilities are already authorized TRICARE providers. However, the number of referrals VA receives through TRICARE is nominal for a number of reasons, including VA's ability to bill for services, which is a similar concern third-party insurers have with DOD and VA. Are DOD and VA looking at ways to improve the billing systems of both sees to facilitate DOD/VA resource sharing, but also to improve third-party reimbursements?

Dr. CHU. DOD has proposed a change in the methodology used to establish third-party reimbursement rates for outpatient services received at military treatment facilities. When the change is implemented, third-party billing will be made on the basis of itemized charges instead of using the current all-inclusive rate method. Extensive system and process modifications are being accomplished to accommodate the new business rules for line-item billing, and a proposed implementing Code of Federal Regulations (CFR) regulation was published March 29, 2002. The current projected implementation date for itemized billing is August 2002, pending approval of the final CFR regulation and system deployment. A financial sub-workgroup under the DOD/VA Presidential Task Force may recommend to the departments' leadership that this itemized billing system be applied to future sharing agreements.

Dr. SNYDER. Dr. Chu, one of the concerns raised has been the inability of DOD and VA to exchange medical and financial information. For the past several years, VA and DOD have been working on developing a Government Computer-Based Patient Record (GCPR) for each Service member. The idea was that Service members would have his or her own computerized patient record that would follow them throughout their career in the military and then be transferred or provided to VA following their departure from the Service. Your written testimony indicates that limited information is being transferred between DOD and VA. When do you expect DOD and VA to both be able to access the entire medical record of a Service member, when necessary? "Has continued funding for this program been included in the Future Year's Defense Program (FYDP)?"

Dr. CHU. The Composite Health Care System II (CHCS II) is the DOD medical and dental, clinical information system that will generate and maintain a comprehensive, lifelong, computer-based patient record (CPR) for each Military Health System beneficiary. CHCS II is currently-undergoing user testing and formal DOD operational test and evaluation. Worldwide fielding of CHCS II is expected to begin in the 4th quarter of Fiscal Year 2002.

DOD strongly supports the need for appropriate sharing of electronic health information across federal agencies and is committed to ensuring that VA has the information required to provide continuity of care for eligible veterans. For near-term information sharing, DOD and VA have collaborated extensively to deliver a technical solution using the Federal Health Information Exchange (FHIE), formerly known as Government Computer-based Patient Record (GCPR), an interface between DOD's CHCS I and Veterans Health Information Systems and Technical Architecture (VISTA). DOD has transmitted protected health information on approximately 3.7 million retired and separated Service members to VA. The Defense Enrollment Eligibility Reporting System now provides personnel separation notifications, and DOD will continue to transmit protected health information to VA.

DOD has followed congressional direction regarding project funding; DOD spent $6 million on GCPR in Fiscal Year 2001 and has programmed approximately $6 million annually for Fiscal Years 2002–2007.

Dr. SNYDER. Ms. Dorn, in your written statement, you indicate that the coordination of information technology in medical care is important to managing care and will likely require a sustained, multi-year effort. Historically, particularly within the Department of Defense Health Program, ensuring that technology requirements are

adequately funded has been a problem. Has OMB indicated to the Departments that these information technology requirements should be fully funded to meet the President's Management goal? What efforts, if any, are being taken to ensure that these requirements are being adequately funded?

Ms. DORN. OMB is working closely with the Departments to ensure that the two key information technology efforts outlined in the President's Management Agenda are being completed, as they are critical to successful VA/DOD coordination.

Enrollment System: For over 20 years, the DOD has operated a centralized automated system to enroll and track individuals having entitlements to DOD benefits and services called the Defense Enrollment/Eligibility Reporting System (DEERS). The Departments are exploring how VA and DOD can both use the DEERS for veterans' benefits and services on an interoperable basis so that veterans will not be asked for information already in DOD computers. Alternative approaches and timetables are being jointly developed now by the Departments. OMB is ensuring that the effort is being anticipated in the Departments' early development of the FY 2004 budget request. Funding needed prior to FY 2004 should be sufficiently covered in our current request.

Patient Record System: Both Departments are currently developing patient record systems, which are funded in their respective budgets. OMB is using the apportionment process for both DOD and VA to manage funding to ensure that the final product is an interoperable and efficient system.

Dr. SNYDER. Dr. Wilensky, in your written statement, you indicated that the Benefits Services Workgroup would look at eligibility, access and the different benefit structures. Do you expect the Task Force to include in its recommendations how the priority of access for the two distinct programs may be combined? For example, if we have truly joint facilities, who would have priority access between an active duty member and a 100 percent disabled veteran. Or, as resources become more scarce, the priority between military retirees and category 7 veterans?

Dr. WILENSKY. Task Force work groups have requested and are currently receiving agency specific data related to this question. At present, it is too early to determine what outcomes analysis of this information will yield. In general, it appears as though priority access in joint facilities is determined by medical need and acuity once eligibility is established. Clearly, the more efficient and effective the continuum of healthcare and the delivery of that healthcare becomes, the more transparent access to health care will be for beneficiaries. Task Force work groups have issued multiple calls for data to determine how to best articulate recommendations for changes, if any, access to health care for both veterans and military retirees. Just as in the past, however, local coordination and a renewed communication of requirements, on both sides, will result in development of more appropriate actions to provide access to care. To date, it appears the issue of access to care for various beneficiary groups is handled on the basis of a clinical decision. The more urgent the clinical need, the quicker the medical response, regardless of eligibility criteria.

While joint ventures are not the only vehicles for improving the delivery of health care for veterans and military retirees, their role should not be ignored. It is, in all likelihood, no longer appropriate to designate them as "pilot projects" promising uncertain results. The very term "pilot projects" suggests a tentative commitment. Joint ventures have been successful. It is no longer a question of having them, but of institutionalizing the "best practices" identified in them. Our veterans and military retirees are best served when joint ventures succeed everywhere as the result of the permanent reforms of committed departmental secretaries.

PTF work groups are now developing initial recommendations, to be included in the July Interim Report. Following submission of the Interim Report, further work group analysis will focus on root causes of these eligibility and access barriers and will detail those causes in the Final Report, to be submitted in March 2003. This process should assist avoidance of unintended consequences and provide efficiency in implementation planning.

Thank you for the opportunity to respond to this question.

Dr. SNYDER. TRICARE Prime requires specific access standards for their beneficiaries. Would your members expect the VA to meet these same standards of care?

Mr. WASHINGTON, for The Military Coalition. Yes, theSpecific TRICARE Prime access standards would have to be met. The Coalition supports any efforts to improve coordination between the Departments, but only if thoseefforts would enhance or maintain access to health care, quality, safety, and services offered to beneficiaries of each department.

Mr. ROBERTSON. Absolutely! The American Legion would expect VA to meet these same standards of care for all veterans enrolled in the VA health care system. However. TRICARE Prime patients should never have priority of care over service-connected disabled veterans. These contracts are suppose to be offered when VA has

excess capacity. If VA is unable to meet acceptable access standards for its enrolled veterans' population, then they should not be taking on additional TRICARE Prime patients.

Mrs. HOLLEMAN. Indeed, TRICARE Prime Beneficiaries (whether active duty families or Military Retirees under 65 and their families) would expect that the same TRICARE access standards would apply to them in a VA facility as would apply in an MTF or a TRICARE network. We realize, of course, that could cause real difficulties. The VA has never had to operate under such time constraints. This could cause true hard feelings from VA beneficiaries if the way to meet the access standards was to put a DOD beneficiary ahead of a waiting VA beneficiary. However, the TRICARE access standards are a major part of the TRICARE benefit. It guarantees quality health care by requiring that problems be dealt with in a timely fashion. It is a crucial protection and one that the TRICARE beneficiaries would not be willing to give up. Indeed, if a VA facility is presently in a TRICARE Prime network (as many are) they should be following the access standards at the present time.

Mr. THOMAS. Absolutely! Having said that, it must be realized that the VA workload exceeds that of individual TRICARE providers many times over. If VA could achieve access standards equal to that of TRICARE, our members and all veterans would be more than satisfied with the services provided.

Ms. ILEM If VA is designated as a TRICARE Prime provider, I believe that TRICARE Prime beneficiaries should expect to receive the same access standards as provided in their health care plan, whether they seek care through an authorized private provider or VA. Unfortunately, VA would likely be unable to meet the TRICARE Prime access standards for care for either TRICARE Prime or VA beneficiaries given the negative impact of chronic under funding of the veterans' health care system. Continued budget shortfalls have placed significant stress on the VA health care system and resulted in rationing of care for thousands of veterans, including service-connected disabled veterans, and unprecedented waiting times.

Mr. CULLINAN. The VFW absolutely believes that VA should meet the same standards currently used by TRICARE Prime. This has the advantages of better improving immediate coordination between the two agencies as well as the potential to encourage integration at local levels that will lead to enhanced access to health care facilities and treatment.

DOD's TRICARE Prime providers clearly demonstrate a high standard of safety, service and quality to their beneficiaries. We certainly favor those same standards for all VA beneficiaries too.

Dr. SNYDER. As beneficiaries of the two systems, what incentives do you think needs to be in place to have the systems work together more effectively?

Mr. WASHINGTON. The Coalition strongly recommends development anddeployment of a common DOD–VA medical record as quickly as possible, along with the capability to exchange data seamlessly between the two systems using appropriate privacy protections. Development of such a record has thepotential to improve the efficiency and effectiveness of both the VA health care and claims systems, lower DOD and VA medical expenditures, facilitate data exchange for research and other purposes, and help service members andveterans get better health care and prompt, accurate disability decisions.

In addition, The Coalition advocates permitting individual facilities to retain some or all of the cost savings achieved through sharing efforts. The Coalition believes this would provide a tremendous (financial) incentive for both VA and DOD to pursue collaboration efforts.

Mrs. HOLLEMAN. It is crucial that effective cooperation between the two systems be seen as a major part of the job of the commanders and directors of MTFs and VA facilities. It should be part of the job that is judged when analyzing an executives' effectiveness. If a local facility, be it DOD or VA, saves money by coordination the facility should retain some of the savings. It should see a practical advantage to the effort such coordination requires. It should retain at least some of the savings and its yearly budget should not be lowered to reflect the retention.

If a single lifetime health record is developed and put into effect it will make Doctors and other health care providers practice much easier and more efficient. This in and of itself is an incentive for coordination and sharing. This would improve the professional lives of the health care providers as well as the beneficiaries.

Mr. ROBERTSON. Obviously, leadership is paramount! Daring a visit to a joint venture physical plant in New Mexico, the staff summed it up nicely:"When we work things our locally, we can reach consensus, but when it goes beyond the local level, it is usually a disaster!" Buy-in is also critical. Everyone involved must put the care and treatment of the veterans as the top priority. VA's "Putting Veterans First" slogan must be a shared goal of both systems. Reciprocal reimbursements should be

paid in a timely manner. Incompatible billing and collection seems to create an uncomfortable atmosphere between agencies.

Mr. THOMAS. Firstly, not all veterans or members of PVA are beneficiaries of 'both' systems. Only under a joint agreement that would consists of 'complete' integration, would all veterans be beneficiaries of both systems.

I believe that both systems should have performance standards that are equal across the board. Under TRICARE contracts if the provider cannot achieve appropriate performance standards, contracts are not renewed. This type of standard should also be in place within the VA healthcare system.

Ms. ILEM. Currently, there are no real incentives in place to encourage local Department of Defense (DOD) and VA hospital directors to develop joint sharing agreements.

VA hospital directors' job performance is evaluated through specific performance standards. Their ability to meet or exceed these performance measures directly impact upon monetary reward and salary bonuses. If this type of objective is built into both VA and DOD hospital directors' performance standards, it may be a motivating factor for them to more aggressively pursue joint cost saving ventures. Likewise, this or similar objectives that directly impact promotion, salary increase, or other desirable rewards may heighten combined VA/DOD interest in developing joint sharing initiatives. If VA and DOD hospital directors are effective in finding ways to save the government money through joint sharing ventures, they should be rewarded for their efforts. Likewise, if no attempts are made to develop sharing agreements where feasible, this should be taken into account as well. Hopefully, making improvements to better serve their respective patients more efficiently and effectively would be enough incentive to consider and develop joint sharing agreements where appropriate.

Mr. CULLINAN. The VFW suggests that the first, single most important action needed, is to have DOD and VA medical resource sharing in a common/standardized medical records system. Such a system has the obvious advantages of being more cost-effective and more customer-oriented.

An immediate follow on incentive to this suggestion for common record sharing should be to allow the separate facilities to retain a portion of the cost savings they achieved provided this additional money is spent to upgrade/improve their information and technology sharing systems. This could result in better coordination in such wideranging fields as medical R&D efforts and to improve upon the VA's disability decision processing and their 60 year old disabilities rating schedule.

QUESTIONS SUBMITTED BY MR. MORAN

Mr. MORAN. Dr. Mackay, you published a very interesting article in the Washington Times on March 6, 2002, "Defending veterans medical deductibles," in which you stated the VA health care system is stressed with the large influx of veterans turning to VA for care. You wrote of two solutions: Restricting enrollment or imposing a deductible, VA opted for a $1,500 deductible. The article did not broach the issue of sharing resources with DOD to help deal with this problem. Does VA see DOD as a viable partner to help you deal with this particular problem?

Dr. MACKAY. Sharing with DOD is a source of savings and efficiencies, but increased resource sharing with DOD will not provide sufficient resources to meet VA's core funding needs totally. VA and DOD have obtained significant savings in joint pharmaceutical purchases and joint purchases of medical/surgical supplies of approximately $ 100 million in FY 2001. Nevertheless, a key issue has yet to be resolved: What is VA's role with DOD, i.e., equal partner or a subcontractor under the TRICARE contracts? VA has found that DOD contracts with managed care support contractors under TRICARE are an obstacle to direct VA/DOD sharing .Many DOD facilities will not enter into direct sharing agreements for clinical services if there is a TRICARE contract in place. VA may only provide heath care services to DOD beneficiaries (including active duty members) under VA/DOD sharing authority, when such services *are not* included within the TRICARE contract. The TRICARE contracts are very comprehensive and include a myriad of inpatient, outpatient, and ancillary health care services. Until this issue is resolved, it is unlikely that there will be any significant increase in sharing of clinical services.

Mr. MORAN. Your written statement forecasts an increase in acceptance of DOD TRICARE beneficiaries. Yet, Members continually receive information concerning wafting times of up to a year or even more for veterans to obtain a primary care appointment in VA medical centers and community-based clinics. Are these positions consistent, with veterans waiting long periods for care while VA may accept TRICARE beneficiaries?

Dr. MACKAY. By law, VA–DOD sharing agreements involving the treatment of TRICARE beneficiaries must result in the improvement of services to eligible veterans at the facility and must not result in the denial of, or delay in providing, access to care for any veteran at that facility (Public Law 102–585, §202). Some VA medical centers have space available and some do not. In FY 2001 TRICARE collections were $9.8 million, and there were only five VA medical centers with TRICARE collections of $500,000 or more.

Mr. MORAN. VA and DOD collaboration has been in place for 20 years. Why were sharing agreements in place a few years ago suspended by the advent of TRICARE rather than incorporated into the TRICARE program?

Dr. MACKAY. Currently, VA serves as a subcontractor to DOD's managed care support contractors. Many DOD facilities will not enter into direct sharing agreements for clinical services if there is a TRICARE contract in place. After October 1, 1999, DOD authorized TRICARE contractors to assume workload and pay bills previously handled by the military services through VA–DOD agreements. This workload was to be brought into TRICARE provider networks, but no provisions were made to assure that the workload continued to be supported by VA versus one of the other network providers. VA is working with DOD on its next generation of contracts to assure that it will encourage beneficiaries to obtain health care from VA.

Mr. MORAN. The DOD is currently implementing a new clinical information system called "Composite Health Care System II (CHCSII)." It incorporates many technological capabilities and produces an electronic patient medical record. Given the fact that the VA's clinical information system is almost 20 years old and in need of replacement, is there any reason that elements of the DOD system could not be tailored for use at the VA? Would such a consolidated medical record system produce benefits to advance VA–DOD sharing?

Dr. MACKAY. Today, VA already has a continuously updated, high performance health information system, VistA, which has been acclaimed as a model for the future of health information systems and is getting even stronger as VistA enhancement are implemented. The VistA system is operating throughout VA in 1,300 sites of care and is being strengthened and enhanced for the future. VA's health sytems provide a range of integrated, patient-focused applications to support patients across a range of care settings. VA has received recognition in the mainstream press, as well as in the professional literature, for its robust, efficient, integrated health systems. A recent *Wall Street Journal* article (12/10/01) about VHA information technology highlighted several innovations that have had a positive impact on patient safety and the delivery of patient care, and an article published in the Journal of the America Medical Informatics Association (Sept./Oct. 2001) noted the flexibility and level of integration provided by the Computerized Patient Record System (CPRS), the centerpiece of VA's health systems. CHCS II is a developing system that holds promise as well but is not yet a completed system. VA and DOD will continue to explore how the two organizations can benefit from their current and future systems and will be exploring convergence of VA and DOD health information applications consistent with mission requirements.

A close collaborative partnership, under the titles of the Federal Health Information Exchange (FHIE) and HealthePeople (Federal), exists between the VA and DOD to exchange data and develop a common health information infrastructure and architecture comprised of standardized data, communications, security, and high performance health information systems.

This two phase effort will exchange patient data and will result in computerized health record systems that ensure interoperability with DOD's CHCS II an VA's HealtheVet strategy for VistA (HealtheVet-VistA). The first phase of this plan, FHIE, focuses on DOD providing information to VA clinicians and includes the Federal Health Information Exchange (FHIE, formerly Government Computer-Based Patient Record) effort, already in testing as of the end of calendar year 2001. The second phase, HealthePeople (Federal), uses convergent strategies and is a joint VA and DOD effort to:

- Improve sharing of health information;
- Adopt common standards for architecture, data, communications, security,technology, and software;
- Seek joint procurements and/or building of systems;
- Seek opportunities for sharing existing systems and technology; and
- Explore convergence of VA & DOD health information applications consistent with mission requirements.

Mr. MORAN. Knowing that the DOD and VA have unique and differing missions, but also recognizing that there exist great similarities in their clinical operations, how would you propose to evaluate the DOD CHCS II system for possible use at

the VA? Could this evaluation be tied in to the test sites envisioned in the legislation recently proposed by Chairman Smith (HR 2667)?

Mr. MACKAY. VA's VistA system is a fully functional inpatient and outpatient information system today and could probably be used in joint sites with some modification. CHCS II is not yet a fully operational system, e.g. the current phase addresses only ambulatory care. VA does not believe either system can deal with the near term needs of joint sites. Near term, the test sites will use a combination of business rules and parts of both software systems to support patient care. Elements of VistA and CHCS II will both likely be part of near term strategies.

For the long term, the prospects are very good. To support all sites including joint sites, a "convergence" strategy of common data/communication standards and software will be used to address long-term efforts. Specifics are outlined in the bullets to question 4.

Mr. MORAN. The DOD has invested significant funding in its new clinical information system. Do you agree that it is in the best interest of the government to investigate how to best take advantage of this existing investment in clinical technology?

Dr. MACKAY. DOD and VA are both actively investigating how to best take advantage of both the DOD investment in CHCS II and the VA investment in VistA through the joint strategy outlined above.

Mr. MORAN. In 1998 VA's senior health executives (its VISN Directors) identified as their most pressing business problem the VA's inability to track patients between and among facilities, this due mainly to having separate patient data files at each facility. The DOD's new clinical information system is designed with a single data repository for all patient clinical and demographic information. Use of this system could improve the patient tracking issue. Does the VA plan to evaluate this element of the DOD system?

Dr. MACKAY. VA and DOD are both developing health data repositories to support patient care and are actively sharing information on how best to develop the repositories to be sure that data may be shared between the two repositories while still protecting patient privacy when needed. Together the two repositories will provide all the necessary cabability to track patient care when appropriate and authorized, and to carry out needed research and analysis as people move between the two health care systems. The two are very large complex repositories that need to be separately managed in order to ensure privacy and high levels of performance.

Mr. MORAN. Could you please describe the process a soldier, sailor, airman, or marine currently must go through when he or she leaves active duty and the military health system, and wants to enroll at the VA for medical care? How could this process be simplified and made more cost effective through the use of unified clinical information systems?

Dr. MACKAY. Following discharge from active military, naval, or air service, veterans are required to complete VA Form 10–10EZ, Application for Health Benefits to enroll for VA health services. An application can be completed at any VA health care facility, community based clinic, or on-line at http://www.va.gov/.

Once a veteran is enrolled in the VA health care system, clinical information is accessible through VA's Computerized Patient Record System (CPRS). CPRS is in use at all VA hospitals. CPRS provides health care providers a single interface to review and update a patient's medical history, test results, and drug prescriptions.

As mentioned previously in question 4, a collaborative partnership, under the titles of the Federal Health Information Exchange (FHIE) and HealthePeople (Federal), exists between the VA and DOD to exchange patient data and develop a computerized health records system. More specific details are contained in the last paragraph and bulleted items in question 4.

Mr. MORAN. The VA's most recent submission to Congress of its major medical facility construction priorities lists a project in Anchorage, Alaska, a $59 million project that is intended to supplement this existing joint venture sharing arrangement at Elmendorf Air Force Base Hospital. This project would consolidate all VA activities in Anchorage (now in three locations), and is listed as a very high priority for the VA. Considering the impact on security concerns since the events of September 11th, has the priority for this particular project changed, and if so, in what ways? If it has not,changed, should it be changed, and why?

Dr. MACKAY. The priority for the Anchorage consolidation project has not changed even though the events of September 11th have added to the challenge for the VA and the Air Force to work out a plan that allows the needed access to the Elmendorf base by veterans, their families, and VA staff. Currently, both VA and Air Force are actively working on the security issue and feel that a solution will be reached. Therefore, VA does not believethe prioritization needs to be changed.

Mr. MORAN. Since September 11 security on military posts as well as all Federal facilities has significantly increased. Does this new heightened sense of security re-

quirements pose challenges that might overwhelm or perhaps hinder the purposes of any joint VA and DOD facilities?

Dr. MACKAY. Our joint facilities reported widely varying responses on this issue. The heightened security has caused concerns for staff reporting for work, patients attempting to obtain care, and family members attempting to visit hospitalized patients. Our DOD partners have, made efforts to accommodate the needs of all mentioned, but the needs are sometimes difficult to accommodate and still maintain security at a level required by the current conditions in effect. With time, security arrangements are being evaluated and, when necessary, revised to balance all needs.

Mr. MORAN. In quoting your statement at the hearing: "During the 1990s, flexibility was given to VA and D0D to establish locally developed rates for medical sharing agreements. This has resulted in the creation of multiple reimbursement rate structures across the country. The variability in payment structure makes the administration of the billing and collection process more difficult. Establishing standardized reimbursement procedures for sharing agreements between medical facilities will eliminate a significant barrier to increased sharing between the two departments." It was Congress that gave local commanders and VA Medical Center directors authority to set local rates, in order to make VA/DoD sharing more meaningful to them and easier to achieve. Your statement suggested that the opposite has occurred. Can you elaborate?

Dr. CHU. Developing rates based on cost data is a significant challenge for both departments' field staff, and can create unnecessary adversarial relationships between the two parties if either side does not believe the rate to be accurate. These rates are often negotiated flat rates that remain in place for the length of the contract instead of being reviewed and updated annually. Additionally, multiple rates have resulted in confusion and errors in billing between the two departments. To simplify the billing process and ensure annual updates of the reimbursement rates, we are considering using the CHAMPUS Maximum Allowable Charge (CMAC) as the basis for negotiated rates. CMAC is regionally adjusted to account far local pricing differences, is automatically updated each year and is easily accessible an a website. We believe standardizing rates will ease resource sharing negotiations and improve the business process.

Mr. MORAN. You indicated you have been examining VA/DOD sharing, and you mentioned number of the same sites our staff visited that led them to produce the staff report that has been mentioned. The staff report discusses several barriers to sharing, including incentives and disincentives, leadership issues, rotation policy, etc. Based on your travels to some of these sites, do you agree with or disagree with our staff's views on these matters, and why?

Dr. CHU. Although I am not familiar with the staff report you are referring to, I can report that during my travels I have been universally impressed with the level of cooperation and collaboration in the field. While I believe there is still more work to do, I have seen more activity in the field between DOD and VA than I believe our data systems report or we in Washington understand. I had cordial, candid discussions with Iboth DOD and VA leaders. I do believe we need to do more to support our leaders acrossthe board by removing barriers such as a lack of a national reimbursement rate, better exchange of electronic information, and reviewing our pharmacy and supply systems to maximize our resources. We are working all of these issues at the national level.

Mr. MORAN. You also testified about the joint sites and partnerships that you have observed and cite their advantages. Did you see any disadvantages in the joint sites, and what do you think they may be? How may these disadvantages be overcome?

Dr. CHU. As expressed in my testimony, the joint venture partners are working hard to put their limited resources to the best use in meeting the needs of their patients. They are very successful in meeting that goal. At the same time, they are all somewhat different and at different stages of maturation. There are dissimilarities associated with the separate missions; the staff of one partner is mostly military, while the other is all civilian. There are fiscal and logistics considerations associated with the differences in how the respective departments conduct business. I wouldn't classify any of those as disadvantages. It is clear evidence of the ability of the two systems to collaborate effectively and, at the same time, support their departmental missions.

Mr.MORAN. We often hear the word "readiness" in answer to the question about why military treatment facilities and VA medical centers do not share. Yet, William Beaumont Army Medical Center is totally integrated with the VA Clinic in El Paso, and you testified about Albuquerque and Las Vegas joint ventures. Do these existing sites and their working philosophy of jointness make moot the "readiness" issue?

Mr. CHU. I would not accept readiness as a reason to not share health care delivery resources. When we design mutually beneficial health care management models, such as these joint ventures to help us improve our capability to deliver care, it can have a positive impact on readiness.

Mr. MORAN. Mr. Ross Perot once said, "Show me how a company's computer system works, and I will show you how the company works." Do you believe that if the DOD and VA standardized clinical information and computer systems that this would be a good step and contribute to overall DOD/VA cooperation?

Dr. CHU. The development of common standards for Information Technology (IT) architecture, data, communications, and security is important to ensure that DOD/VA information systems are interoperable. Efforts between DOD and VA to move toward achieving these common standards are ongoing. DOD and VA have collaborated extensively to deliver a near term solution for the Government Computer-Based Patient Record (GCPR) that has enabled DOD to transmit protected health information on approximately 3.7 million retired and separated Service members to VA. The Defense Enrollment Eligibility Reporting System now provides personnel separation notifications, and DOD transmits this protected health information to VA. DOD currently is fieldtesting a standard-based electronic medical system that includes a national clinical data repository — Composite Health Care System II (CHCS II). DOD strongly encourages the joint development of a clinical data repository using DOD's CHCS II to facilitate continuity of care and improve health care delivery throughout the Service member's lifecycle.

Mr. MORAN. What would be the clinical benefits and cost savings if the DOD and the VA were to use the same clinical data standards and information systems?

Dr. CHU. DOD strongly encourages the joint development of a clinical data repository (CDR) using DOD's Composite Health Care System II (CHCS II) to facilitate continuity of care and improve health care delivery throughout the Service member's lifecycle. A CDR is a central database of individual, electronic, lifetime patient records that authorized users throughout the healthcare enterprise can access to view comprehensive patient information, to perform analyses, and to add to the data. DOD strongly supports the need for appropriate sharing of electronic health information across federal agencies and is committed to ensuring that VA has the information required to provide continuity of care for eligible veterans. The CHCS II CDR will capture data from different clinical information systems and store it in a common format, making the data meaningful to health care providers and other authorized users. DOD and VA would benefit by using the same data model and a services-based architecture such as that employed by CHCS II.

To further enhance the sharing of information between the Departments, DOD also has offered the following systems for use by VA:

- Defense Medical Logistics Standards System (DMLSS): DOD's award winning, state-of-the-art technical solution improves medical logistics responsiveness at reduced costs and provides a high quality, integrated system. Joint use of DMLSS would allow standardization of logistics data and material management practices, thereby enhancing efficiencies in operation and allowing VA to capitalize on DOD's investment in the development of DMLSS.
- Centralized Credentials Quality Assurance System (CCQAS): Maintains all medical provider information in a single Tri-Service database. Sharing electronic provider credentialing and privileging information between the two agencies will result in improved patient access and quality of health care. DOD, VA, and HHS personnel have begun to meet to study the merits of potential integration of CCQAS with the Veterans' Administration Professional Review Program (VetPro). DOD and VA also should explore opportunities to converge efforts to track risk management and adverse actions, currently developed in the newest version of CCQAS, in order to improve patient safety and quality assurance.
- Pharmacy Data Transaction Service (PDTS): Allows DOD to build a medication profile for all patients. DOD and the VA are evaluating sharing this service to improve VA quality of prescription services and to enhance patient safety by reducing the likelihood of adverse interaction between two or more drugs, therapeutic overlaps, and duplicate treatments.

Mr. MORAN. Since September 11, security on military bases as well as at all federal facilities has significantly increased. Does this new heightened sense of security requirements pose challenges that might overwhelm or perhaps hinder the purposes of any joint VA and DOD facilities? Please elaborate.

Dr. CHU. So far the evidence suggests that the answer is "no." As you point out, all federal facilities have increased security screening since September 11. But there are no apparent security-related effects that are greater because of their joint arrangement. The aftermath of September 11 included total lockdown at military in-

stallations around the world. It also caused dramatic increases in security at VA facilities. For a very brief period of time no one — DOD or VA — could get to a military medical treatment facility from off base. The joint venture managers worked with their local security personnel and developed systems to permit patients to access the medical facilities. For the foreseeable future, all medical facilities, on base or off base, separately operated or joint venture, will have greater access controls. There is no indication that these pose insurmountable barriers to the beneficiaries.

Mr. MORAN. The VA's most recent submission to Congress of its major medical facility construction priorities lists a project in Anchorage, Alaska, a $59 million project that is intended to supplement the existing joint venture sharing arrangement at Elmendorf Air Force Base Hospital. This project would consolidate all VA activities in Anchorage (now in three locations), and is listed as a very high priority for the VA. Considering the impact on security concerns since the events of September 11, has the priority for this particular project changed, and if so, in what ways? If it has not changed, should it be changed, and why?

Dr. CHU. The Department of Defense has not changed its position of supporting the existing joint venture sharing arrangement at Elmendorf. I understand that the VA's priority for its medical facility construction project at Elmendorf Air Force Base has also not changed since the events of September 11. To ensure that security concerns do not result in a change to the project's priority, the Air Force and the VA are working on a plan that will allow needed access to Elmendorf by veterans, their families, and VAfacility staff.

Mr. MORAN. TRICARE seems to be a major impediment to VA/DOD sharing. Is this true, and what can be done to change this situation?

Dr. CHU. On the contrary, TRICARE is not an impediment to sharing. TRICARE is the peacetime component of our military health care program. It is the only foundation on which partnership with VA can reach its full potential. As my testimony elaborated: "As DOD moves toward a more proactive partnership with the VA, we have established shortterm goals to be accomplished during this fiscal year. These include establishing solid business procedures for reimbursement of services, improving access to health care through VA participation in TRICARE, examining opportunities in pharmaceuticals, facilitating health care information exchange between the departments, and establishing a long-range joint strategic planning activity between DOD and VA."

Mr. MORAN. VA and DOD collaboration has been in place for 20 years. Why were sharing agreements in place a few years ago suspended by the advent of TRICARE, rather than incorporated into the TRICARE program?

Dr. CHU. VA and DOD have collaborated for more than twenty years and the Department continues to view that relationship as one of great importance. In that regard, there has never been a suspension of sharing with VA. DOD policy encourages the expansion of sharing wherever it is beneficial to the Department. If new sharing opportunities emerge, there is nothing in DOD policy that would prohibit, or even discourage, the development of a new agreement within its policy guidelines. At a May 17, 2000, congressional hearing on VA/DOD sharing, the GAO testified that since TRICARE changes went into effect, 82 percent of VA respondents reported that none of their local sharing agreements with DOD have been terminated and a majority reported that the volume of sharing activity had either stayed the same or increased. Of those who reported that agreements had been terminated, more than two-thirds said that the VA facility would continue to provide services to DOD beneficiaries under TRICARE. At present, the number of facility-to-facility sharing agreements and associated revenue reported by VA has declined while there has been, at the same time, a corresponding increase in TRICARE network-based revenue for VA facilities.

Mr. MORAN. Your statement discussed the DEERS system, the large DOD personnel database, currently collecting and storing benefits eligibility information for over 20 million beneficiaries. Why would up-front costs be required for VA to access DEERS? Does such a financial requirement imposed on VA establish a barrier to sharing the DEERS system, rather than speeding the way to sharing?

Ms. DORN. VA has a consultant to quickly assess several approaches to transitioning to the DEERS database. Up-front costs are being used to make this assessment, and will be used to make any software and hardware changes to the systems to make them interoperable on a real time basis. The financial cost of the switch from the current enrollment systems to the DEERS system does not impose a barrier to sharing. In FY 2002 and the next five years, VA had budgeted over $92 million for enrollment IT requirements for its *current* system. Some of these expenditures would disappear and funds would be diverted to the transitioning process. It is expected that additionalfunding would be minimal.

Mr. MORAN. Your statement boasts of 137 VA Medical Centers now contracting with TRICARE, but VA's testimony shows very little actual TRICARE services being provided in VA facilities. VA has ambitious plans, but what is going to change the environment that produces numerous contracts but little real patient care activity?

Ms. DORN. We recognize that there are barriers which need to be identified and resolved to allow more DOD/VA patient sharing. The senior leadership of both departments created a DOD/VA Executive Council to facilitate a renewed focus on sharing and coordination. Recently, the Deputy Secretary of Veterans Affairs and DOD Under Secretary for Personnel and Readiness approved joint standardized billing and reimbursement rates to address a barrier to the implementation of sharing agreements. In addition, they established a plan to develop a joint health information exchange and a team to develop a DOD/VA strategic plan. DOD and VA are working together to design the next generation of TRICARE contracts so that they maximize coordination. Chairman Smith introduced H.R. 2667 last year. The Committee asked for the Administration's views many months ago, however we have not received a response. May we receive these views by March 29?

Ms. DORN. The Administration supports the goals of H.R. 2667 that pilots facility sharing that includes sharing of information technology and human resource systems as well as space. To promote the success of these pilots, we are working with DOD and VA to identify any needed language modifications. We will forward such language to you in the near future.

Mr. MORAN. Could you please comment on the savings which might be realized if the VA and DOD used a standardized clinical information system? What would be the best way to measure any savings?

Ms. DORN. An interoperable, computerized patient medical record system used by both DOD and VA will improve quality of care, reduce cots on duplicated patient tests/procedures, and save IT system costs. However, the savings will be in the out years. The best way to measure any savings will be to compare the cost of the joint efforts to what it would have cost individually without this initiative.

Mr. MORAN. The VA's most recent submission to Congress of its major medical facility construction priorities lists a project in Anchorage, Alaska, a $59 million project that is intended to supplement the existing joint venture sharing arrangement at Elmendorf Air Force Base Hospital. This project would consolidate all VA activities in Anchorage (now in 3 locations), and is listed as a very high priority for the VA. Considering the impact on security concerns since the events of September 11th, has the particular project changed, and if so, in what ways? If it has not changed, should it be changed, and why?

Ms. DORN. The priority for this project has not changed. However, this year's VA budget concentrated on high priority seismic correction projects in California to meet safety goals. As a result of the severe and far-reaching hospital damage sustained in California after the 1989 and 1994 earthquakes, the State enacted laws that mandate seismic upgrading for existing facilities with specific goals by 2002, 2008, and 2030. Most other major construction has been delayed while VA completes its infrastructure realignment study (CARES) to ensure that construction plans align with final determinations. The prioritization of the Alaska project is not affected by increased security concerns from the September 11th incidents. VA and DOD have developed tentative procedures for the Alaska proposal that will enable both access and security.

Mr. MORAN. Based on your experience, both in government and in the private sector, are there medical and administrative advantages for VA and DOD to having a unified set of clinical data standards that describe patient's condition and course of treatment? And if so, would the serviceman going from active duty to veteran status gain benefits if the DOD and VA were using a unified set of standards and systems?

Dr. WILENSKY. Clearly, the more transparent the transition from service member to veteran status, the more efficient and effective will be the continuum of healthcare and the delivery of that healthcare. Task Force work groups have issued multiple calls for data to determine how to best articulate recommendations for development of common system architectures, both clinical and administrative.

Mr. MORAN. In your current role as Co-Chair of the Presidential Task Force, is it your intent to examine potential benefits of a unified set of clinical data standards and systems for use by both the VA and DOD?

Dr. WILENSKY. The Task Force work groups have requested and are currently receiving agency specific data related to this question. At present, it is too early to determine the outcome of analysis of this information.

Mr. MORAN. What barriers to sharing have you observed between VA and DOD? Are these barriers cultural, administrative, or budgetary in nature, and what action should be taken to relieve them?

Dr. WILENSKY. Obviously, differences in missions and populations served as well as the barriers to sharing are many and varied. Each of the areas mentioned present specific challenges. This does not mean there are not many opportunities for sharing despite the challenges and impediments as well as additional areas that exacerbate sharing between the agencies. PTF work groups are now developing initial recommendations, to be included in the July Interim Report, which will respond to several of these areas. Following submission of the Interim Report, further work group analysis will focus on root causes of these barriers and will detail those causes in the Final Report, to be submitted in March 2003. This process will avoid unintended consequences and provide efficiency in implementation planning.

Mr. MORAN. You have unique experience in health care finance, which often "seeks the cure" for what ails us with financial incentives. What incentives (or disincentives) do you see at work in VA and DODhealth resources sharing, and can these be changed?

Dr. WILENSKY. Varied expectations related to agency interrelationships have an impact on financial incentives, as well as many other activities. Leadership is a critical element as well. Work groupanalysis of all available data will be completed and presented to the Task Force to frame recommendations to change both expectations, financial and otherwise, and future activity in the two agencies. As an economist, increasing incentives will be important to achieve increasing health resources sharing and may be considered as part of our final recommendation.

Mr. MORAN. Since September 11, security on military posts as well as all federal facilities has significantly increased. Does this new heightened sense of security requirements pose challenges that might overwhelm or perhaps hinder the purposes of any joint VA and DOD facilities?

Dr. WILENSKY. In terms of military base access to joint VA and DOD facilities, as a result of military security requirements, September 11 may have aggravated the situation, but the problem existed long before 911. Just as in the past, however, local coordination and a renewed communication of requirements, on both sides, will result in appropriate actions to provide access to care. September 11 should not become an excuse for resisting future VA/DOD collaborative initiatives.

Mr. MORAN. Mr. Washington, you discussed a number of strategies that lead to better coordination. We were very pleased to see that the Coalition supports better coordination for the "future veteran," especially those now deployed overseas. The points you raised — procurement, pharmacy, IT, etc., avoided a discussion of the direct delivery of clinical care. Should the Committee infer from this that you are opposed or at least concerned about the idea of VA and DOD facilities sharing responsibility for delivering direct health care to each other's beneficiaries?

If your answer is "yes," how do you reconcile it with the existing joint facilities such as at El Paso, Texas, where our staff reported very high rates of patient and provider satisfaction?

Mr. WASHINGTON for The Military Coalition. The Coalition maintains that there are significant near-term opportunities to allow for increased collaboration between the two agencies to improve beneficiaries' health care. First and foremost is the VHA's role as a TRICARE network provider of clinical services. The VHA as a TRICARE network provider (of clinical services) is a promising source for improved access to quality health care for all DOD beneficiaries. If capacity permits without compromising its core mission, then by all means the VHA should play a vital role in offering primary and specialized clinical care to TRICARE beneficiaries as a TRICARE network provider.

The Coalition is pleased that the VHA is represented in discussions centered on crafting the next generation of TRICARE contracts (T–NEX). The Coalition notes in a recent hearing before the Senate Personnel Subcommittee on Armed Services, Dr. Winkenwerder, ASDHA affirmed with regard to T–NEX development, there would be "appropriate opportunities for VHA participation in provider networks." The Coalition supports greater utilization of VHA networks in partnership with TRICARE. Expanding the use of VHA facilities as TRICARE-authorized providers to care for all TRICARE beneficiaries may improve active duty and retirees' access to clinical care in areas where TRICARE Prime is not available or there is limited network development. In light of the growth of VHA's Community Based Outpatient Clinics (CBOCs), the VHA could provide an additional clinical service delivery alternative for TRICARE beneficiaries.

The Coalition supports the programs underway at the joint use facilities and believes such cooperative efforts should be expanded to other areas where there are co-located DOD and VA facilities. Where the two systems can take advantage of each others' facilities and capacity for radiology, specialty care or primary care, the Coalition believes it only makes sense to do so. As indicated in our testimony, the criteria for measurement of merit the Coalition would apply to such efforts is wheth-

er they would enhance or maintain access to health care, quality, safety, and services offered to beneficiaries of each of the department's stakeholders.

Mr. MORAN. The focus of your testimony was on TRICARE. As OMB stated during the hearing, VA has 137 TRICARE agreements, but Dr. Mackay's statement admits low workload. What are the problems there in your view, and can they beaddressed?

Mr. ROBERTSON. The American Legion believes the problems may very well be the difference between intent and reality. The intentions may be very sincere, but the realities may be prohibitive:

1. In many VA medical facilities, the length of waiting periods for appointments may be unacceptable to TRICARE.
2. Since enactment of TRICARE for Life, TRICARE may choose not to send Medicare-eligible enrollees to VA, because VA would have to bill TRICARE instead of Medicare.
3. To save money, TRICARE may choose to use their preferred providers first before exercising VA options.
4. Billing and collection problems between VA and TRICARE became apparent.

Local fixes to these realities would include:

1. Employing more VA health care providers to reduce length of waiting periods for appointments.
2. Authorize VA to bill the Centers for Medicare and Medicaid Services (CMS) for the treatment of non-service-connected medical conditions, especially for Medicare-eligible veterans.
3. For dual-enrolled veterans in Priority Groups 1–6, VA would be considered a TRICARE preferred provider and no third-party reimbursements would occur.
4. VA needs to either improve its billing and collection process or outsource the service.

Mr. MORAN. Mr. Robertson, should Congress advance legislation to move VA more toward TRICARE? Should TRICARE policy itself be a target, or should the focus be on VA?

Mr. ROBERTSON. Clearly, there is a difference between a Federal agency and a for-profit contractor. The American Legion believes VA is fully capable of becoming a health care partner with DOD. Between these two large health care delivery systems, the health care needs of both systems' beneficiaries could be met through cooperative and collaborative efforts, yet with clear lines of distinctions. There would still be a need to contract with local health care providers in under served catchment areas.

Unlike TRICARE, VA would not have a profit motive, but a health care delivery motive. Therefore, meeting health care demands would have a higher priority than showing a profit. The primary focus would be quality of care rather than minimizing expenses and cutting costs. However, VA would have to improve its ability to bill, collect and retain all copays deductibles,premiums, and third party reimbursements. DOD would have to share the equitable cost of care for its beneficiaries and its capital assets and infrastructure. The goal would be providing quality care in the most timely and appropriate setting.

The American Legion's GI Bill of Health was crafted just prior to the establishment of TRICARE. The similarities between the GI Bill of Health and TRICARE are amazing:

- Enrollment,
- Defined health benefits packages,
- Bill, collect, and retain all copays, deductibles, premiums, and all third party reimbursements, and
- Open to eligible dependents.

However, there were also major differences:

- The American Legion wanted to improve, strengthen and preserve VA's special services to include long-term care, spinal cord injury, blind rehabilitation, etc.
- Initially, TRICARE was not available to Medicare-eligible beneficiaries.

As TRICARE contracts were awarded, billions of dollars in "seed" money was paid to TRICARE contractors to prepare to treat the first patient. Had DOD chosen to work with VA, those billions would have resulted in immediate health care delivery. As a result of the decisions of the Base Realignment and Closure (BRAC) Commission, some of the lost DOD medical facilities became VA medical facilities. Had DOD chosen to work with VA, other lost DOD medical facilities may have remained operational as Community Based Outpatient Clinics (CBOCs), as VA opened nearly 500 CBOCs during this time period.

As DOD negotiates the next generation of TRICARE contracts, The American Legion sees several changes in the contractual relationships:

- Increase in health care costs.
- TRICARE for Life.
- Ongoing negotiations with TRICARE subcontractors.

Initially, DOD had seven TRICARE contractors and now they are down to five. Should DOD fail to reach agreement in a TRICARE region, The American Legion believes VA should be given an opportunity discuss enhanced sharing opportunities to provide quality health care delivery for DOD medical beneficiaries.

Mr. MORAN. Mr. Robertson, do you think legislation that "deems" a thing to come true makes something come true? We already "deemed" VA hospitals to be TRICARE providers in 1999, but VA and DOD have not been able to execute an agreement to activate the arrangement contemplated. In this light, what recommendations can American Legion add to resolve the dilemma?

As a Federally chartered organization, The American Legion takes the sense of Congress very seriously. However, TRICARE contractors are profit driven and tend to focus on the dollars and cents of Congress. If the desire of Congress adversely impacts on the chief financial officer's bottom line, chances of compliance are equally diminished. If VA could not bill TRICARE for the treatment of patients referred to them by TRICARE, VA would be swamped with TRICARE beneficiaries.

Unfortunately, the solution to this dilemma lies in the terms of the next generation of TRICARE contracts. The American Legion believes if there are built-in fiscal incentives for utilization of VA and TRICARE agreements, the "deems" of Congress would be met.

The American Legion continues to champion VA and DOD sharing to provide timely, quality health care services to America's veterans, especially those with service-connected disabilities.

Mr. MORAN. VA has one of the world's finest spinal cord injury systems. Should the child of an active duty service man or woman, injured in an accident with a spinal cord compression and in need of rehabilitation, be able to receive that care at one of VA's 23 spinal cord centers assuming capacity were available?

Mr. THOMAS. This question addresses tree pivotal elements, capacity, funding and access.

Current law accompanied by VHA Directive 2000–022 requires VA to maintain capacity at Spinal Cord Injury (SCI) Centers by setting targets for staffed beds and FTEE. Unfortunately, despite constant monitoring, VA has yet to meet these targets for, staffed acute and long-term care beds at all SCI centers. These resource shortfalls continue to have an adverse effect on veterans' access to SCI care. Under these circumstances, admitting non veterans for care at VA SCI centers would create additional re-direction of resources away from veterans care and parallel conflicts of access pitting eligible veterans against non veterans in competition for care. While VA SCI care is second-to-none in U.S. health care and has much to share with other private and public health care providers, we do not see how this conflict could be easily resolved.

Assuming 'adequate capacity' was available, not only in the SCI center but throughout the VA medical facility, appropriate rehabilitation of children would probably require additional ward space. It would not be appropriate to co-mingle children with aging veterans during the rehabilitation process. Psychological considerations are much different with children than that of adults, especially older adults. Typically children (under 18 years) require special needs due to bone growth considerations which may also require some specialized equipment.

VA spinal cord centers service veterans suffering from spinal cord injury/disease based upon benefits earned during service to our country. The funding provided allows for the complete continuum of care, not just the rehab following spinal cord injury or disease.

On the other hand, a dependent child of an active duty service man or woman receives their healthcare from a DOD facility or in the private sector utilizing Tricare. For the purpose of argument, Tricare would be managed care, and medical services udder managed care are rationed according to pre-determined formularies. Under the managed care formula, length of stay and services are considerably different than those afforded veterans receiving services from VA. Who would determine what services and length of stay would be appropriate for a non-veteran? Who would set reimbursement rates? Under existing law VA could provide services under the 'humanitarian rate' structure. Since this is significantly less than the actual cost of services, the VA would have to absorb the difference.

Mr. MORAN. If VA has specialized resources for rare or difficult to treat problems, do you believe we ought to make maximal uses of these, to ensure that their costs are properly managed?

Mr. THOMAS. Yes. VA has a long way to go to achieve full capacity in its specialized services in order to achieve full maximum efficiencies.

Mr. MORAN. If a VA hospital is next door to an Army hospital, should that VA hospital be able to buy an expensive machine without considering the needs of ifs Federal neighbor?

Mr. THOMAS. As mentioned in my testimony, resource sharing between VA and DOD should be maximized where practical. Obviously when two medical facilities are 'next door' to each other, the sharing of very expensive equipment should be considered and taken advantage of when possible. Given the history of tight budgets, every effort should be made to maximize VA and DOD's ability to acquire equipment and supplies without sacrificing patient safety and delivery of services to both populations.

Mr. MORAN. During the hearing you provided us with an example of how DOD and the VA have "different types of care." Your anecdote described a pregnant woman during the floods in Texas who had to deliver her baby in a VA hospital because no "regular hospitals" were available. The doctor who delivered her baby had no prior experience performing this procedure and as you mentioned, was coached over the telephone. Could you please provide me with a possible alternative for any woman who is faced with this situation? Wouldn't a VA hospital be a safe place for a woman to give birth if there were no other available medical facilities?

Mr. THOMAS. Certainly a VA hospital, or for that matter any hospital should be a safe haven for anyone in need of emergency medical treatment. However, without adequate facilities for certain specialized services, e.g.: Obstetrics, Nursery, etc. once the emergency condition is stabilized (in this case delivery) the patient(s) should be transferred to an appropriate facility.

Mr. MORAN. In your testimony you said, "Simply put, we will support only that that does no harm to the beneficiary no matter the cost savings that may be generated." Can you amplify a bit for the benefit of our Members what you mean by this?

Mr. CULLINANE. Over the past decade VA as well as DOD personnel accounts have suffered from severe funding in the annual budged/appropriations cycle as well as the imposition of so called "efficiencies" and management initiatives that have been directed toward one single goal-reducing federal expenditures. It is evident to the VFW that the detrimental affect this would have on active duty and veteran's programs, services and health care was not once a factor in these budgetary equations. Similar to the plight of VA, DOD medical care has suffered from inadequate oversight, insufficient funding and greatly diminished infrastructure and capacity as result of base closures and budget driven efficiencies.

As a consequence veterans are today forced to wait months and even longer before they can access their health care systems and often many months for primary and specialty care appointments. Health care for active duty military as well as their dependents, particularly in remote and overseas locations, has also been far from adequate. In another area, it now takes years in some instances before VA benefits claims are properly adjudicated thereby denying veterans and their dependents earned and, often times, desperately needed compensation and services.

It is for this reason that the VFW will only support legislative initiatives that are specifically directed toward enhancing the availability, quality and accessibility of VA and DOD programs and services. In the event savings are realized in the process, then such resources must be immediately reinvested into the respective systems. Those proposals that would pare back VA and DOD programs and services merely for the sake of "balancing the budget"—past year's reconciliation actions and the precipitous decline in active duty personnel levels come to mind—are totally unacceptable.

The VFW does not oppose and, in fact, actively supports initiatives directed toward making these Departments more efficient and effective—but only in the service of those it is formally dedicated to serve, this nation's veterans. In other words, the VFW will only support that which does no harm, those things that clearly stand to benefit our current andformer defenders in uniform.

Mr. MORAN. Your statement suggested Medicare subvention, rather than VA–DOD sharing, has a more lucrative potential for the VA system. As you know, we have supported, voted for, and passed VA-Medicare subvention several times, but our colleagues in the Senate have yet to act, even though Senator Specter has championed it for years as a good option for older veterans. So far, the DOD's Medicare Subvention experience is less than successful. Do you have any recommendations on how we might proceed on subvention to avoid some of DOD'sproblems with it?

As stated in our written statement, the VFW supports Medicare Subvention as a potential source of additional nonappropriated dollars to augment the VAMedical Care budget. Additionally, it would also have the beneficial effect of providing Medicare eligible veterans with the option of electing VA as their Medicare provider. Under this scenario the system would benefit from aninfusion of desperately needed

additional dollars and certain veterans would enjoy enhanced access to a form of health care of their choosing.

It is emphasized that subvention will only work to the betterment of veterans and the VA system if there is no consequent "offset" from, or reduction in annual appropriations support.

With respect to the unsuccessful DOD subvention pilot project, it is our view that this undertaking was veritably designed to fail. The Balanced Budget Act of 1997 authorized the Department of Defense (DOD) to conduct the Medicare subvention demonstration for a three-year period. Due to extended delays in implementation, the pilot was only carried out for a year, with little or no chance of accurately accessing its true merits and/or shortcomings.

Once initiated, DOD formed Medicare managed care organizations——collectively called TRICARE Senior Prime——at six sites that provided the full range of (Medicare-covered services as well as additional DOD-covered services, notably prescription drugs. It has also been reported that a number of these areas had relatively higher numbers of sicker—more costly——patients than represented nationally.

Further, under a proviso of the Balanced Budget Act of 1997 mandating ongoing Level of Effort of services (LOE) by DOD, the Centers for Medicare andMedicaid Services (CMS) was to pay DOD for Medicare-covered care of theenrolled military retirees if DOD continued to spend on all aged military retirees at least as much as it had historically. Under the subvention demonstration, Senior Prime enrollees' care in 1999 cost DOD far more than the Medicare capitation rate that was established for the demonstration. This mainly resulted from enrollees' heavy use of medical services, but DOD coverage of prescription drugs——not included in the Medicare benefit package——also contributed to its high costs.

As reported in an October 2001 GAO study, without the demonstration, Medicare spending in 1999, the pilot's first full year of operation, for retirees who enrolled in Senior Prime would have been, on average, about 55 percent of the Senior capitation rate. The Balanced Budget Act's payment rules resulted in no Medicate payment to DOD in 1999. This was because they were ostensibly designed to prevent the government from paying twice for the same care——once through DOD appropriations and again through Medicare. The rules also required that the payment be adjusted to account for Senior Prime enrollees' health status. It must also be emphasized that even in the event that DOD had received some Medicare payments, there still would have been a serious shortfall since the Balanced Budget Act capped total payments at $60 million for 1999, well below what would have been provided under then current capitation rates.

In order for VA Medicare Subvention to achieve the desired result of shoring up the VA Medical Care system and avoid the problems that confronted DOD:

- Subvention must be implemented uniformly nation-wide so that theoutcome is not distorted by regional variations in sick vs. healthypopulations. This is also an issue of equity in that it would avoiddiscriminating between other wise eligible veterans based solely ongeographical location.
- There must be no annual cap on Medicare payments to VA. As was demonstrated with the DOD pilot, such an arbitrary upper limit wouldonly place VA in a position to lose dollars relative to CMS with noreasonable expectation of recouping even a modest portion of the cost ofproviding care to an expanded Medicare eligible veteran patient workload.
- The Level of Effort (LOE) requirement must be eliminated. While theTrust Fund may be technically comprised of "federal" dollars, it isseparate and discreet from the General Treasury from which VA appropriations properly flow as directed by the Congress and Administration. With respect to the provision of health care, VA should be treated no differently than any other provider. In the extremely unlikely event that VA becomes over funded under subvention, Congress is appropriate entity to take corrective action.
- The CMS capitation or payment formula must be adjusted to accommodate medical services actually provided by VA as opposed to only those currently covered under Medicare. As has been documented by the DOD pilot as well as the current situation in the private health care market, this is particularly urgent with respect to the provision of Managed Care which is the primary VA modality. Ancillary to this, payments to VA must be at a 100% rate and not at a reduced or discounted rate relative to other providers as has been proposed in earlier legislation.
- Full appropriation support must be maintained with absolutely no reduction in funding as a consequence of subvention funding. These dollars are to be applied to remedying over a decade of under funding of VA Medical Care and to cover the cost of providing for an expanded Medicare eligible patent workload.

• VA billing procedures and infrastructure must be greatly modified andimproved to allow for the proper and timely billing of Medicare as well asother 3rd party payers.

QUESTIONS SUBMITTED BY MR. THORNBERRY

Mr. THORNBERRY. With the recent Title 10 and Title 32 activation of the National Guard and Reserve what can DOD/VA do to ensure personnel in rural regions of the country, that are not in close proximity to a military installation but are close to a VA medical center, receive adequate medical care?

Dr. MACKAY. Based on a longstanding Memorandum of Understanding (MOU) between VA and DOD, DOD may refer active duty members, on a reimbursable basis, to any VA medical facility for treatment when the treatment requested is not otherwise governed by procedures established under a local sharing agreement. In cases where a VA health care facility has an established sharing agreement with a DOD facility, the provision of the sharing agreement will govern the care provided to active duty personnel.

National Guard and Reservists on active duty (other than active duty for training) are under the direct jurisdiction of DOD. To obtain care for active duty members, DOD should advise military installation commanders to work closely with their local VA health care facilities to ensure needed medical care is coordinated for active duty personnel. Upon completion of the time called or ordered to active duty, eligible National Guard and Reservists should be advised to seek care from their nearest VA health care facility. The eligibility of National Guard and Reservists varies depending on length and period of active military service.

Mr. THORNBERRY. With the recent Title 10 and Title 32 activation of the National Guard and Reserve what can DOD/VA do to ensure personnel in rural regions of the country, that are not in close proximity to a military installation but are close to a VA medical center, receive adequate medical care?

Dr. CHU. There are more than 160 VA medical centers and 800 VA community-based clinics. The majority of those are situated in areas that are remote from Military Treatment Facilities. Most VA facilities in those areas have been providing health care to military personnel under agreements with the military services. At present, there are several hundred agreements between VA facilities and Reserve and National Guard units for the provision of a variety of health services. As a result, we are confident that, wherepersonnel and VA facilities are in close proximity, the VA facilities will be able to provideadequate medical care.

Mr. THORNBERRY. A problem that has come about as a result of Guard/Reserve activation is family members now being enrolled in TRICARE with no health care providers in their region accepting TRICARE. Is there something being done to ensure care for these families is being provided?

Dr. CHU. Yes. We wanted to ensure that families of Guard and Reserve members called up would have maximum opportunity to continue with the health care providers they use under health insurance coverage they may have through their employment. In order to test how best to achieve this, we have instituted a demonstration program, effective last September, to improve the benefits for families of Guard and Reserve members activated for Noble Eagle, Enduring Freedom, and related activities. The demonstration includes three components: waiver of annual deductibles, waiver of non-availability requirements, and an increase in the amount the government will pay on claims from non-participating providers — up to 115 percent of our normal allowable amount.

QUESTIONS SUBMITTED BY MR. ORTIZ

Mr. ORTIZ. How is the Department of Defense working together with the Department of Veterans Affairs to consider Naval Hospital Corpus Christi as one of the three integration demonstration sites, and where is the DOD in this process? Thank you.

Dr. CHU. Final decisions have not yet been made concerning development of a plan to demonstrate fully integrated operations at three sites, but we are working with the VA on this issue.

QUESTIONS SUBMITTED BY MR. RYUN

Mr. RYUN. There are veterans in our country who feel the current system works because it allows access to the "best of both worlds" for healthcare. How would the

healthcare sharing initiatives proposed help to improve the system for veterans in a "real world" scenario?

Dr. MACKAY. Greater coordination between VA and DOD has direct benefits for veterans. Sharing information and technology can speed up service, ensure safer healthcare, and inform veterans of earned entitlements. In addition, it can transport information from one Department to another —— providing innovative managers ways of improving service. Improvements in enrollment systems would allow veterans and their families to provide information one time for multiple types of VA benefits. Interoperable computerized medical records would allow rapid updates including information on medications. When VA and DOD share facilities, veterans benefit by being able to access additional services in the same facility.

Mr. RYUN. It is clear that the veterans healthcare system needs more funding. I have experienced this within my own district. How would you respond to the idea that this funding shortfall should be addressed through inter-department planning and reimbursement agreements, rather than forcing restrictions on beneficiary access with the "sharing" concept?

Dr. MACKAY. VA supports inter-department reimbursement (sharing) agreements for many reasons. Economies of scale occur when Federal facilities are encouraged to refer patients for services to each other. Local referrals to a Federal partner allow the referring facility to maintain control of its patient. Procuring VA services for DOD patients can frequently be accomplished at less cost than buying these services from a civilian provider or moving the patient to a more distant military facility. Taxpayers also benefit from maximizing the use of existing Federal resources.

QUESTIONS SUBMITTED BY MR. RODRIGUEZ

Mr. RODRIGUEZ. With a new round of base closures on the horizon, could there be consolidation of certain VA and DOD medical facilities?

Dr. MACKAY. DOD has not yet identified new bases/hospitals for closure. After DOD submits a list of base/hospitals for closure to Congress, VA would have to review the list of military treatment facilities (MTFs) facing possible closure before VA could make an assessment. VA and DOD consolidations were discussed in previous base closings, but no consolidations of MTFs and VA medical facilities occurred. Generally, TRICARE contractors assumed MTF workload in previous base consolidations.

Notwithstanding the above, both VA and DOD are committed to developing a process for joint strategic planning for facility construction and utilization to maximize resources and improve coordination of delivery of high quality care to VA and DOD beneficiaries. VA and DOD have agreed to greater participation by DOD in future VA CARES studies to ensure that potential facility sharing opportunities are appropriately addressed and discussed. As in the previous CARES study in VISN 12, which resulted in a close partnership between Reserve Training Center, Great Lakes, IL, and N. Chicago VAMC, VA anticipates options for joint facility utilization would be considered.

Mr. RODRIGUEZ. Aside from the cultural differences, what would be the feasibility of such a move?

Dr. MACKAY. Conceptually, MTF–VA facilities make sense provided the facilities: (1) Are within a reasonable distance of each other; (2) the consolidation has the support of the beneficiaries of both Departments in the geographic areas covered; and (3) the VA facility has additional workload capacity and medical care capability to handle the DOD beneficiary population. VA does not provide pediatric or adolescent health care services. Also, DOD would have to agree that the local VA facility would assume the additional MTF workload. Generally, TRICARE contractors in previous are consolidations absorbed MTF workload.

VA and DOD have different health care missions that must remain the first priority in determining the resource utilization models for both Departments. Any option recommending consolidation of VA and DOD facilities would be considered on the basis of the impact on the beneficiaries and improved coordination for the continuum of care. Moreover, please note that in many cases it is most advantageous to combine or augment discrete specialties, functions, and/or processes rather than simply merge overhead structures.

Mr. RODRIGUEZ. Is additional legislative authority needed to facilitate greater cost sharing between DOD and VA?

Dr. MACKAY. No additional legislative authority is needed to facilitate greater cost sharing between VA and DOD. The primary legislative authority for health resources sharing between the two Departments is the Veterans Affairs and Department of Defense Health Resources Sharing and Emergency Operations Act (38

U.S.C. section 8111). The law encourages sharing of health resources on a voluntary basis between MTFs and VA medical facilities. The law eliminated legislative barriers to sharing. However, in recent years DOD's policy has been to use TRICARE contractors' provider networks for most care outside of MTFs. This has resulted in a diminution of direct sharing arrangements between MTFs and VA facilities.

Under Tricare for Life (TFL), Medicare is the first payer. If VA were to assume a greater role in care for aged military retirees, the authority to bill Medicare for services would greatly facilitate this program.

Mr. RODRIGUEZ. What savings can you project if cost sharing was optimized between DOD and VA?

Dr. MACKAY. Optimal cost sharing (cost avoidance) between DOD and VA depends upon many variables including changes in policy and patterns of utilization. The primary focus of VA–DOD sharing is to allow facilities to expand services for its beneficiaries. At the same time, however, cost savings (cost avoidance) occur, especially in the purchase of services. Nonetheless, VA cost avoidance in collections and purchases in facility-to-facility sharing are difficult to quantify due to changes in policy and patterns of utilization and the inability of current accounting systems to capture such sharing information. In addition, overall VA/DOD sharing is relatively small. For instance, in FY 2001 VA collections and purchases associated with VA–DoD agreements totaled $48.3 million.

Currently, many DOD facilities will not enter into direct sharing agreements for clinical services if there is a TRICARE contract in place covering these services even if cost avoidance can be clearly demonstrated. Another reason that cost avoidance is difficult for VA to quantify is changing patterns of utilization. Total VA users increased from 3.3 million in FY 1998 to 4.1 million in FY 2001. The number is expected to increase to over 4.5 million in FY 2003.

Mr. RODRIGUEZ. In light of the recent implementation of TRICARE For Life, do you foresee a day when the VA will be able to provide medical services to military retirees? Or when veterans could be treated at DOD medical facilities?

Dr. MACKAY. Currently, any military retiree may choose to enroll with VA to receive medical care based on universal eligibility. Under the new TFL benefit, some military retirees may elect to receive more of their care through alternative sources because DOD TRICARE co-payment requirements may result in higher out-of-pocket costs to military retirees choosing to utilize their TFL benefit at VA facilities. Generally, military retirees are the only veterans eligible for medical treatment in DOD facilities; however, in some cases local sharing agreements may permit VA beneficiaries to utilize DOD medical assets subsequent to implementation of a specific sharing agreement.

Mr. RODRIGUEZ. With a new round of base closures on the horizon, could there be consolidation of certain VA and DOD medical facilities?

Dr. CHU. We don't see a need for consolidation of facilities under any base closure scenario. More likely, the VA might use facilities DOD closes. The reassignment of missions and most base personnel during these closures eliminates the need for a military medical facility. There are now VA facilities located at several former military installations, e.g., Mather, Williams, and Griffiss Air Force Bases and Orlando and Mare Island Naval Bases. When VA assumed operations at those locations, the Department worked out agreements with the VA facility, where necessary, to treat any remaining personnel in the area.

Mr. RODRIGUEZ. Aside from the cultural differences, what would be the feasibility of such a move?

Dr. CHU. As far as any future base closures are concerned, consolidation of facilities is not likely to be economically feasible.

Mr. RODRIGUEZ. Is additional legislative authority needed to facilitate greater cost sharing between DOD and VA?

Dr. CHU. No. We believe that sufficient authority exists to support sharing activities.

Mr. RODRIGUEZ. What savings can you project if cost sharing was optimized between DOD and VA?

Dr. CHU. The answer will be the sum of savings resulting from the optimal sharing of resources at all places where meaningful sharing can occur. That will first require a complete enumeration of all combinations of beneficiary populations and facilities of the two agencies that afford even a potential for sharing. Once the locations are identified, the requested answer will require careful analyses of the types of sharing that are possible and economically sound in each location. The savings possible in each location are likely to be highly specific to that location — depending on such factors as the size and demographic needs of the population, the availability of resources to share, and the extent of capitalization required to accomplish the sharing.

Analyses currently underway by the Presidential Task Force, supported by both agencies, are beginning the first task of identifying the geographic combinations of populations and facilities where significant sharing is possible. When that is completed, analyses of the second form can be conducted.

Mr. RODRIGUEZ. In light of the recent implementation of TRICARE For Life (TFL), do you foresee a day when the VA will be able to provide medical services to military retirees? Or when veterans could be treated at DOD medical facilities?

Dr. CHU. Under our current arrangements, VA facilities that are TRICARE network facilities can provide services to military retirees, and be reimbursed under TRICARE. Most VA facilities are network providers. The same rules apply to retirees who are TFL beneficiaries as apply to retirees under age 65: TRICARE pays the VA facility a negotiated rate, and the VA facility collects the cost share of 20 percent from the beneficiary.

Veterans who are military retirees are currently eligible for care in military facilities. Extending access to other veterans would require a statutory change, unless VA "bought" the care from the military facility. This is now done at some locations, and we are exploring mechanisms that would encourage more such arrangements.

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