FIELD HEARING ON HEALTH CARE RESOURCE SHARING

HEARING

BEFORE THE

SUBCOMMITTEE ON
HOSPITALS AND HEALTH CARE

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

SECOND SESSION

FIELD HEARING HELD IN AUGUSTA, GA, FEBRUARY 18, 1994

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CONTENTS

FIELD HEARING ON HEALTH CARE RESOURCE SHARING

FRIDAY, FEBRUARY 18, 1994

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The subcommittee met, pursuant to call, at 9:04 a.m., in the banquet room, Alumni Center, Medical College of Georgia, 919 Fifteenth Street, Augusta, GA, Hon. J. Roy Rowland (chairman of the subcommittee) presiding.

Present: Representatives Rowland and Johnson.

OPENING STATEMENT OF CHAIRMAN ROWLAND

Dr. ROWLAND. It is a real pleasure for me to be here this morning and to see all of you. I want to thank all of our witnesses for coming today and also want to recognize the veterans who came out for this hearing this morning. I also want to recognize my good friend Doug Barnard. Doug is sitting back here somewhere—Doug, thank you very much for being here. [Applause.]

I am very pleased to be joined by my good friend and colleague, Don Johnson, who represents the 10th District now. Congressman Johnson is a recognized veterans' advocate and was instrumental in arranging this hearing.

As a graduate of the Medical College of Georgia, I am particularly appreciative of the hospital of the Medical College, and I want to thank them for allowing us to utilize this facility this morning.

With all the debate in Washington regarding the current VA health care system and the changes that may occur under national health care reform, I believe it is an opportune time for us to examine the level of health care resource sharing between the Augusta VA Medical Center, the Department of Defense's Eisenhower Army Medical Center, and the Medical College of Georgia. Specifically, this hearing will focus on both current and proposed sharing agreements between these facilities as well as the role resource sharing may play under national health care reform.

We will also hear from our witnesses on how such a research sharing enhances their ability to provide quality medical care to their respective beneficiaries.

As many of you know, the President's national health care reform proposal, or whatever other proposal that may be adopted, would change the way health care is provided. Under these reform proposals, health care providers would be forced to compete against one another for individual enrollees. It will be a survival of the fit-

test. If a facility of a health care provider cannot compete for patients, then it will have to scale back the health care services that it can offer. Some people wonder if Federal health care providers such as the VA and DOD can compete in such an environment. I believe they can. However, it will be necessary for both to ensure their respective beneficiaries that they can provide timely access to quality health care.

With respect to the VA, I am firmly convinced that the quality of care in VA facilities is comparable to the quality of care in the private sector. However, access to that care has been a problem. All too often, VA hospital directors find themselves unable to meet the demands for health care because they are not given sufficient funds. That must change or VA will not be able to compete in the changing health care environment. VA is not alone here. DOD health facilities face many of the same challenges. Likewise, private health providers will have to change the way they do business in order to compete under national health reform.

In addition to resources, it will be necessary to give health facility directors increased flexibility to respond to local needs and to make strategic health delivery decisions at the local level. Local directors must have sufficient flexibility to address specific and unique areas of need. One way for VA facilities to address local shortages and better meet the demand for care is to encourage the hospital directors to enter into expanded sharing agreements with DOD facilities and with affiliated medical schools as a means of providing a broader range of services. Under such sharing agreements, I believe VA can better meet the health care needs of veterans and can better compete in the changing health care environment.

Currently, we can see the benefits of the sharing authority right here in Augusta. As the range of sharing opportunities increases, the cost effective delivery of high quality specialized medical care to veterans has increased.

I want to commend Tom Ayres, who has been a very active proponent and who has worked hard to get these types of expanded sharing agreements in place at the Augusta VA Medical Center.

As the list of specific sharing agreements between these three institutions is extensive, I will submit it for the record. However, I want to highlight some of the agreements. For example, Eisenhower's neurosurgery program has been consolidated with the VA's neurosurgery section at the VA Medical Center. In addition, Eisenhower and the VA have shared invasive cardiology support during May 1993. The Georgia Radiation Therapy Center developed at the Medical College is another excellent example of a shared community resource. Patients from the Medical Center, Eisenhower and the VA are treated at the center, which avoids duplication of expensive resources and personnel. Finally, other potential areas of collaboration include full integration of the residency program and telemedicine.

So I look forward to hearing the testimony of our distinguished witnesses today. And I now want to recognize my colleague for any statement that he would like to make. Don, thank you very much and thank you for all the help that you have given in being an instigator in putting this hearing together.

OPENING STATEMENT OF HON. DON JOHNSON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Mr. JOHNSON. Thank you, Mr. Chairman. I just want to take this brief opportunity to welcome your Subcommittee to Augusta and the 10th District of Georgia, and to thank you for agreeing to chair this important hearing here on cost-sharing agreements. I want especially to welcome you back to your alma mater, the Medical College of Georgia. We are all glad to have you back here.

As you noted, Mr. Chairman, we are here today to discuss the important role facilities such as the Eisenhower Army Medical Center, the Veterans' Affairs Medical Center and the Medical College of Georgia will play in the debate on health care reform, which I might point out, you have had such an instrumental role in. And I want to point out to the people of Augusta and the 10th District that you have got a very important proposal of your own on health care reform and one in which I plan to support you because I think the initiatives that it includes are very vital to the debate and should be a very important part of health care reform.

Whereas, presently the Federal agencies are feeling the impact of severe budget cuts, here we have three institutions who are consolidating their resources where practical, and providing high quality health care services to DOD beneficiaries, veterans and civilians alike. As we all know, the time has come for us to devise new cost-efficient, effective ways to do business, particularly when it comes to providing health care in this country. I am proud to say that one method is being demonstrated right here in the 10th District—in the area of the 10th District that we are currently sitting.

I think you will find in the course of the morning that these institutions are finding innovative new ways to address many of the issues that you and I are faced with every day. The agreements discussed today will demonstrate three things—(1) how fiscal restraints and downsizing the military have caused us to redefine the roles and missions of many of our installations; (2) the importance of pooling resources to provide quality and service to consumers, and then finally, that the cost effectiveness of these shared agreements should be unquestioned, and we do not need to do anything to muck those agreements up. We have very important results that are going on here and I feel like this will become clearer and clearer as the day goes on.

Again, I want to thank you for this opportunity for us to make known what is happening here. And without further ado, we will move further into the testimony. But thank you again.

Dr. ROWLAND. Very good. And I would like you to join me up here, if you will.

Our first panel of witnesses is Dr. Charles Wray, he is Vice President for Clinical Activities and Vice Chairperson and Professor of the Department of Surgery at the Medical College of Georgia; Brig. Gen. Vernon Spaulding, who is Commander of the Eisenhower Army Medical Center and he is accompanied by Col. Sidney Steinberg; Mr. Thomas L. Ayres, who is Director of the Augusta VA Medical Center and he is accompanied by Thomas Kiernan, Chief of Staff of Augusta VA Medical Center.

Gentlemen, I want to thank all of you very much for being here this morning. I would ask that, if you will, limit your formal testi-

mony to 5 minutes and your entire testimony will be made a part of the record and then those things that you did not get to cover during the testimony, we can bring out in questions.

Dr. Wray, suppose we start with you.

STATEMENTS OF CHARLES H. WRAY, M.D., VICE PRESIDENT FOR CLINICAL ACTIVITIES AND VICE CHAIRPERSON AND PROFESSOR, DEPARTMENT OF SURGERY, MEDICAL COLLEGE OF GEORGIA; BRIG. GEN. VERNON SPAULDING, COMMANDER, EISENHOWER ARMY MEDICAL CENTER ACCOMPANIED BY COL. SIDNEY R. STEINBERG, DIRECTOR OF MEDICAL EDUCATION AND CHIEF OF THE DEPARTMENT OF SURGERY, EISENHOWER ARMY MEDICAL CENTER; THOMAS L. AYRES, DIRECTOR, AUGUSTA VA MEDICAL CENTER ACCOMPANIED BY THOMAS W. KIERNAN, M.D., CHIEF OF STAFF, AUGUSTA VA MEDICAL CENTER

STATEMENT OF CHARLES H. WRAY, M.D.

Dr. WRAY. Mr. Chairman, Dr. Rowland, Don Johnson, we appreciate your being here today. Before I begin, I would like to extend greetings from Dr. Tedesco, President of the Medical College of Georgia. He is vitally interested in the events to be discussed today. His absence actually underscores the great emphasis the Nation is placing on health care issues. Today in Atlanta, Dr. Tedesco is chairing the Health Strategies Committee meeting. Governor Zell Miller appointed this committee to give advice about the direction that Georgia should take to improve the health of our citizens.

Dr. Rowland, if you will permit me a further personal statement, I would like to welcome you here in your role as Congressman and especially state the pride that we have in your accomplishments, both in your service to your community as a physician and as a graduate of the Medical College of Georgia. We have appreciated the advice that you have given to our graduates at the hooding ceremony in recent years, and we thank you for that.

Some of what I say may repeat some of the things that you said and some things are probably well known to you, but I would like to speak of the historical relationships between the Medical College, Department of Veterans Affairs Hospital and the Dwight David Eisenhower Army Medical Center in Augusta.

During the Second World War, the old Forest Hills Ricker Hotel was converted into a military hospital, and following the Second World War, that facility was converted to a Department of Veterans Affairs Hospital. I spent part of my student rotations and resident rotations in that facility, and since I have discovered that more and more people seem to be very, very young, this was in the 1950s and early 1960s. Because of a unique relationship that had been in place between that hospital and the Medical College, when the new Department of Veterans Affairs Hospital was constructed, a site next door to the Medical College was selected, and a physical connection across Harper Street actually exists, to facilitate the movement of patients, staff, physicians and students, so that our integrated and mutually dependent programs would be facilitated.

Likewise, Fort Gordon has developed since the Second World War with early provision of consultative services between the Medical College and the Fort Gordon Hospital. When the Dwight David Eisenhower Medical Center was constructed, there began to be a closer relationship between the Medical College and that facility. Over time, we have shared not only consultative services, but patient care services as well. The professional personnel at Eisenhower Hospital have been well-trained and fully capable to participate in our educational programs, even at the most advanced level.

We in academia are fond of speaking of the three legged stool of teaching, research and patient service, and consider those activities to be interdependent. I believe that the Dwight David Eisenhower Medical Center, the Department of Veterans Affairs Hospital and the Medical College likewise represent a mutually dependent three legged stool. There is thus a need to preserve these consortial relationships for the advantage of all of our citizens.

I would like to speak of some of the programs that you had mentioned that I believe are important economically in our area. The Georgia Radiation Therapy Center was developed at the Medical College as a shared community resource. Patients from the community hospitals as well as the Medical College, Eisenhower and Department of Veterans Affairs are treated there. This facility has allowed us to avoid duplication of expensive equipment and personnel.

Many years ago when the Medical College was in the process of renovating its radiology department, a vascular special procedures facility was developed in which the space and technical personnel were provided by the Department of Veterans Affairs while the equipment was provided by the Medical College. I believe that not only has this saved money, but I would challenge you to find a Veterans' Hospital in this country that can provide angiography procedures 7 days a week as promptly as this facility does. There are other examples of sharing between Eisenhower and the VA. Currently, as you mentioned, the neurosurgical service at the Department of Veterans Affairs provides acute care for both active duty personnel from Eisenhower and veterans at the VA facility. This is a consolidation that has developed in the last year.

I should relate that the Medical College faculty, in many instances, is shared with the Department of Veterans Affairs. The Regents of the University System have allowed tenure to be awarded to some of these physicians. Many of our departments have faculty that are full time or part time at the VA, depending on needs. There obviously are some departments, such as pediatrics and obstetrics and gynecology that do not have services within the Department of Veterans Affairs Hospital because of the predominance of adult males as patients.

Our undergraduate and post-graduate medical education programs are fully integrated with the Department of Veterans Affairs. Nearly all the departments have residents on regular rotations of that facility. As you know, we usually place medical students in programs where there is a full range of educational experiences available.

Another example of cooperative efforts between the Medical College and the VA is a plan that is being developed to bring the two

medicine services closer together. An easily understood example of what is involved, for instance, would be that we might operate one cardiac catherization unit. This sharing of resources and personnel clearly is a benefit.

Historically at the Eisenhower Medical Center, the residency programs there have provided most of the experiences for military physicians, but we have had some rotations between the Medical College and Eisenhower in such departments as Anesthesia, Dermatology, Obstetrics and Gynecology and Surgery.

Clinical and basic research has likewise been a shared responsibility. During the construction of the acute care hospital, considerable space was devoted to research since the Department of Veterans Affairs has supported such activities, particularly with medical school faculties, and ours has not been an exception. Recently, when our Institute of Molecular Biology and Genetics was established, there was a need for temporary space while renovations were being done. The VA gladly participated in this and as a result, more permanent research activities are now ongoing there.

I would like to address the development of future interactions. The Medical College currently has a Children's Medical Center within the confines of its acute care hospital, and currently the architects are working on final plans for a new structure to house the Children's Medical Center. While we have specialists in these areas, this spring two military physicians, one a pediatric orthopedist and the other a pediatric radiologist, will be stationed at Eisenhower and will participate in our programs. We believe it is logical that the bulk of children's care should be carried out through joint cooperation with Eisenhower to provide for active duty military personnel who are stationed there. The child psychiatry program has a long and rich history of cooperation. When our Psychiatry Department was without a chairman recently, Eisenhower provided a section leader for Child Psychiatry. This allowed the continuation of that valuable service.

With the downsizing of military personnel including physicians, we entered into discussions to fully amalgamate and integrate the residency programs. By July of this year, the General Surgery residents at Eisenhower and the Medical College and the VA should be fully integrated into one program and we plan to do the same thing in Orthopedics by next year. Currently a resident from Eisenhower does participate in our Emergency Medicine program.

As you know, one exciting area of collaboration is in telemedicine. As is true in rural Georgia, the military has many remote stations. The telemedicine program at the Medical College has received national notice and is considered the most advanced application of this technology. We think this will be valuable to the Department of Defense in the future.

We would ask your assistance that we be allowed to continue these present interactions. We believe that they are programmed to be mutually beneficial and hopefully less expensive through sharing. We hope that you will be able to relax some of the regulations that inhibit our further interactions.

I appreciate this opportunity to present this information to you and if we can provide further information, please ask.

Dr. ROWLAND. Thank you, Dr. Wray.

General Spaulding.

[The prepared statement of Dr. Wray appears on p. 45.]

STATEMENT OF BRIG. GEN. VERNON C. SPAULDING

General SPAULDING. Dr. Rowland, Mr. Johnson, I sincerely appreciate this opportunity to participate in this hearing and your interest in the exceptional partnership that has developed between the Veterans' Affairs Medical Center, the Medical College of Georgia and Eisenhower. The potential benefits of this relationship are clear and compelling. This morning I would like to describe for you the mission of Eisenhower Army Medical Center, how we have begun to refocus our efforts in the context of health care reform and to discuss some of the many benefits of our joint efforts to improve access to services and reduce costs. I am joined by my colleague, Colonel Steinberg, who serves as Chief, Department of Surgery, and Director of Medical Education.

Dwight David Eisenhower Medical Center is located at Fort Gordon, GA and was dedicated in 1975 in honor of General Eisenhower, the 34th President of the United States. Eisenhower is a fully accredited hospital by the Joint Commission on Accreditation of Healthcare Organization. In addition to the main hospital building, the institution comprises some 35 separate outpatient clinics, education and research facilities. Eisenhower employs 1,600 military and civilian staff and has an annual budget of $148 million. Salaries and supply purchases provide an additional $70 million to the local Central Savannah River Area economies.

Eisenhower provides primary care to nearly 60,000 active and retired military members and their families, who live within 40 miles of Fort Gordon. As the largest tertiary care military referral center in the southeast, we also provide highly specialized referral care to some 1.3 million beneficiaries in seven States and Puerto Rico. The region's medical facilities support Army, Navy and Air Force highest priority fighting forces at Fort Bragg, NC; Fort Benning, GA; Fort Stewart, GA; Fort Campbell, KY; Jacksonville, FL Naval facilities; Kings Bay Submarine Base and others.

Additionally, included in our region are the Commander-in-Chief Central Command, the U.S. Army Forces Command and the 9th U.S. Air Force. Clearly, Eisenhower provides important medical support to our Nation's most visible defense forces.

We provide fully accredited graduate medical education programs in family practice, internal medicine, general surgery, orthopedic surgery, child and adolescent psychiatry. Approximately 110 physicians are in various post-graduate, medical education programs at all times. And each year, we provide nearly 45 fully trained specialists for assignments throughout the Army.

Recently, the Department of Defense announced a significant effort to develop accountable military health plans focused on local military hospital catchment areas led by designated tertiary care centers in 12 regions of the United States. Eisenhower was designated as the lead agent for DOD Region III, which encompasses Georgia, South Carolina and most of Florida. The concept of a regional managed care agent gives Eisenhower the opportunity to define and manage a health plan for the three States in a partnership with a managed care contractor. This program acknowledges

the leadership role of regional medical centers to identify the highest quality, most cost-effective health care available. The development of a military health care plan is critical to ensure that the military health service system optimizes its use of direct care resources necessary to sustain readiness as well as effectively organizing and managing the civilian resources needed to provide the full range of services mandated by the benefits structure of the Civilian Health and Medical Program of the Uniformed Services.

Our relationship with the VA and the Medical College of Georgia and the medical resources found in Augusta will most certainly enhance and facilitate our development as the provider of highly specialized and extensive medical services to the approximately 1.3 million potential beneficiaries in our region. Our VA/DOD relationship is based upon our mutual commitment to a joint venture process to improve service availability and contain costs. This concept supports the goals of Public Law 102–585 of November 4, 1992 and offers a clear example of enhanced governmental efficiency and cost avoidance and improved access to services through joint venturing. To date, we have agreements, as has already been mentioned, in neurosurgery, women's health services, magnetic resonance imaging, reference laboratory support and rheumatology.

The Medical College of Georgia has been a long-term partner of both the VA and Eisenhower. We have traditionally supported each other in training of physicians and other health care professionals. Recently we have commenced a detailed process to explore the benefits of affiliating our graduate medical education programs where it makes good sense to do so. Additionally, we have also started discussions concerning our mutual interests in the emerging technology of telemedicine. The strategic commitment of the Medical College of Georgia to this technology and its potential applications in remote situations that could exist in the context of national defense as well as our consultation specialty service in the southeast suggests that a partnership in this area would benefit the Department of Defense. As you know, Fort Gordon is the Army's signal center, which offers additional synergy to the development of telemedicine applications.

In summary, Eisenhower Medical Center is a value-driven, customer-focused institution moving towards developing programs and services to meet our Nation's medical readiness goals and the expectations of our patients. We have assumed a leadership role in the southeast for medical readiness and the DOD response to health care reform. We are actively seeking to acquire new technologies such as telemedicine to facilitate the achievement of our goals. Our graduate medical education program represents for us our strength and gives us the ability to extend specialty medical services to our region. Our partnership with the VA and the Medical College adds great depth to our capabilities, and more importantly gets at the very heart of health care reform through cooperation across a wide spectrum of issues that offer the potential for improved access and cost containment.

Again, I thank you for your attention this morning and Colonel Steinberg and I will be pleased to answer any questions you might have.

Dr. ROWLAND. Thank you, General.

Mr. Ayres.

[The prepared statement of General Spaulding appears on p. 48.]

[The prepared statement of Colonel Steinberg appears on p. 52.]

STATEMENT OF THOMAS L. AYRES

Mr. AYRES. Thank you, Mr. Chairman, for extending an invitation for me to testify. It is always a pleasure to testify before your Committees over the years. I also would like to thank Mr. Johnson for a recent visit to our hospital. The staff and the patients really appreciated the attention that you gave them yesterday.

As part of my allotted time, Mr. Chairman, I would like to recognize a special guest that is here this morning. Mr. Bill Edgar, Director of the VA Mecial Center in Dublin, GA, a long time supporter of patient care in the Georgia area and a great personal friend, is here this morning, and I would like to introduce Bill, if I could.

Dr. ROWLAND. I wish you would, I did not realize he was here. [Applause.]

Mr. AYRES. Mr. Chairman, the innovation that has taken place between our three fine organizations would not have been possible without risk taking leadership. And I would like to recognize some of these leaders, not all, but some of them—General Officers LaNoue, Cameron, Spaulding, and Colonels Keating, Steinberg, Anderson and Malley from the U.S. Army. From the Medical College of Georgia Dr. Tedesco, the President; Dr. Wray, who is the Vice President for Clinical Services. From the VA, Deputy Secretary Herschel Gober, who was an early on supporter; Art Hamerschlag, who represents VA Sharing; Dr. Tom Kiernan, my Chief of Staff; Chuck Wright, his administrative assistant; Dr. Michael Spencer and Tom Martin, my executive assistant; Carlton Loftis, Contracting and Joan Boudewyss, my secretary.

I will be brief in my testimony since you have been very gracious and other speakers have covered many of the sharing programs that we have.

As you recognize, VA Medical Center Augusta is a two-division, 1,033-bed, highly complex, VA/DOD joint operating medical center. The downtown division is a 380-bed acute medical and surgical facility, including a 60-bed spinal cord injury unit. The uptown division is a 653-bed psychiatric and intermediate medicine facility which includes a 60-bed nursing home care unit. We also employ 2,300 staff for both divisions. I was appointed Director at Augusta in 1990. Since my appointment, the staff and I have worked diligently to renew and enhance VA/DOD relationships. During the past 18 months, I and members of my staff have worked with the Commanders at Eisenhower Army Medical Center and with the VA/DOD group in Washington to create a VA/DOD joint venture for shared services. This innovative operational concept is dedicated to enhancing opportunities for cost effective sharing of medical resources between co-located Federal health care institutions. The intent of this agreement is to consolidate services where practical and cost effective, to avoid duplication, to achieve economics of scale, to take greater advantage of those situations in which one of the two institutions has ample services for which the other institution has a defined need.

This agreement represents a coordinated effort to consolidate where practical an alignment of services and the contributions of the two institutions, so that the consolidation results in equal input of resources by each institution. I am going to skip over parts of my testimony because they are repetitive.

Since the initial approval of the concept of operation, we have identified joint venture coordinators from both the facilities, initiated JVSS management through the executive management team, consolidated neurosurgery and the rest of the services that have been mentioned in previous testimony.

Over many years, the Medical College of Georgia and the VA Medical Center have enjoyed a mutually beneficial affiliation relationship. As a Dean's Committee Hospital, the VA Medical Center has provided an essential clinical training milieu in a broad spectrum of clinical specialties and subspecialties. The VA Medical Center has also produced opportunities for collegial association and training in specialty areas such as acute and long-term psychiatry, substance abuse, physical medicine and rehabilitation, post-traumatic stress disorder and the treatment and rehabilitation of patients with spinal cord injury. The VA Medical Center annually funds 84 resident slots, at a cost in excess of $2.8 million, in addition to the academic benefits of supporting respective residency programs. The VA derives medical care specific patient care treatment and support benefits from the affiliation with the Medical College of Georgia.

The VA Medical Center has come under increased scrutiny by the Office of the Inspector General in regard to sharing and contracting activities. Increased regulatory and procedural demands that have been placed upon the VA Medical Center Director's authority to contract for scarce medical specialists services have resulted in some abrupt though essential changes in contracting and sharing relationships between our two health care organizations. These changes have been uncomfortable for both parties, but decisive management actions have resulted in the development of better cost and pricing procedures. At this present time, the VA Medical Center purchases the following services from the Medical College of Georgia—general medical services, radiology services, neurology services, radiation therapy, anesthesiology, open heart surgical services, nuclear medicine, radiologist services and radiological physics under the scarce medical specialists contracts.

Dr. Wray has alluded to the possible consolidation of cardiology and the potential for realigning a new medicine model at the VA Medical Center which, we believe, will meet the needs of the changes that will take place under national health care reform, however they spin out.

I believe by sharing resources with other Federal health care providers, our affiliates and the private sector providers, the Department of Veterans Affairs will continue to improve its ability to provide high quality care to the greatest number of eligible veterans. Operating with an annual budget is a fact of life in the provision of health care, whether the care is provided by the private sector or in the approach to Federal facilities. With the advent of dramatic changes in the approach to national health care and the development, financing and organization of managed care systems ca-

pable of providing accessible health care for all Americans, we realize the need for flexibility, acknowledge the inevitability of change, and more importantly, reaffirm the value of continuing and enhancing the strengths of cost effective sharing of quality scarce medical specialties with local facilities.

I would be pleased to participate in any questions at your pleasure, sir. Thank you.

[The prepared statement of Mr. Ayres appears on p. 55.]

Dr. ROWLAND. I wish to recognize my colleague Don Johnson for questions at this time.

Mr. JOHNSON. Thank you, Mr. Chairman.

Let me begin with just a general question, and I will start with Mr. Ayres on this. You know, what we are talking about here today primarily is a very innovative approach to providing cost-efficient health care services, particularly with respect to the consolidation of services. I think this offers, not only an example of the good work that you all are doing, but it can offer an example for us to follow in encouraging this in the private sector. One of the problems of course that we have is antitrust laws.

And what I would like for you to do—and I would like to hear from all three of you—I know Dr. Spaulding or General Spaulding is new here and you may not have quite the history on this as the others do, but I would like to have you comment on how you came together and decided who was going to do what in this three-legged stool, and also if you would give us some examples of the effectiveness of it in terms of saving dollars.

Mr. AYRES. Mr. Johnson, I cannot give you specific dollar savings, I did not come prepared to identify the individual dollar savings for the program, but I think the leadership between the three organizations had a vision of a change in the health care industry. The change was driven for the VA on the fact of reduced funding allocations. I think for the U.S. Army and other military components, it was a draw-down of troops and services and I think, for the Medical College of Georgia, it represented a transition from a very fine teaching institution to a dynamic academic teaching, clinical and research institution. I think we are wise stewards of our Nation's assets that are given to us to manage and we realize the cost of health care and the need to conserve these assets and not be concerned about the traditional ideas that each medical facility has to have all the latest innovative technology.

Mr. JOHNSON. Let me interrupt just a minute. Can you just capsulize for us, you know, what the VA hospital is now doing that it did not do before these agreements? In other words, what is your new role with respect to the relationships with these two other institutions?

Mr. AYRES. Well the process that we have described to you this morning has been an ongoing endeavor for over 2 years, or a little more so on our part. I think the latest innovation is what Dr. Wray alluded to, the need to perhaps consolidate cardiology, either at the VA or MCG. Early indications are that it will probably be placed in the VA. This will maximize the efficiency of both organizations, utilizing the expertise that is available in cardiology at the Medical College of Georgia. It will give me an opportunity to convert other resources into much needed support for patient care, and we will

not have to recruit for very expensive health care providers in an area where resources are scarce.

Mr. JOHNSON. Dr. Wray, would you like to comment on it?

Dr. WRAY. I, likewise, cannot provide financial information as you suggest. One of my points was that these things that we are doing did not develop casually in the last few years to respond to things that have happened necessarily in the last 2 years. But there was a strong historical bond, I believe, that the Department of Veterans Affairs by policy had recognized for many, many years that there needed to be cooperation where possible between medical schools and VA hospitals. I cannot give details, but some of the hospitals that are in remote areas would have difficulty recruiting staff and might not be able to have a proper array of specialists, whereas by working together, we were able to provide that resource for multiple populations of people. And so since we had that relationship, then we have tried in recent years to, in addition to meeting our missions of teaching and research and patient care, to do it in a more cost-effective manner. And I think this is the proper approach.

Mr. JOHNSON. You mentioned in your testimony that you would like for us to relax some of the regulations that have inhibited this relationship. Would you comment on what those are? And maybe if you could go even further—I am not sure how familiar you are with this, I may be asking you more than you are prepared to talk about—how it can be carried over into the private sector. We have got a number of hospitals in this community and other major communities that are competing with each other, and I think that most of them recognize that if they could have some of the regulations relaxed, they could work together a little bit better.

Dr. WRAY. Well of course, I would not kid you to think that we are a private business, you know that each of the three of us are bureaucracies.

Mr. JOHNSON. Right.

Dr. WRAY. And the State has its rules that we have to follow and the Federal Government has rules that both the military and the VA are under. For instance, one example that I would give is that as we share personnel back and forth, it is all right at the present time for a military physician to treat active military personnel—if they came to our hospital and there happened to be active duty personnel, that would not be a medical liability problem. However, if they were involved in the care of civilians, there might be medical liability problems, and these problems might not be financial in the usual terms that they are described as a national problem, but a matter of its being a possibility that General Spaulding could say that this activity is actually a part of the duties of that military physician. So those kinds of relaxations of rules, I think would help us.

As you know, the Augusta community has been scrutinized very heavily because of the Federal Trade Commission's activities here, and we also have had a long-time relationship with the University Hospital, and our residency programs also are there. But I think that there has to be consideration given of how we can proceed without winding up in court. We certainly do not want to do that.

Mr. JOHNSON. Let me move back to another issue, and that is the agreement that was reached back in 1990 between the Medical College and Eisenhower to provide graduate training. Could you just tell us a little bit about that and the importance of that relationship?

Dr. WRAY. Well most of the residency programs that I am familiar with that are very, very successful usually have a broad variety of patients that participate in the educational process. In other words, it is very difficult for one hospital to provide the whole breadth and depth of resources that are necessary to educate residents. Now the military has the possibility, for instance, if they need for their resident to have some experience in pathology, just to assign to the Armed Forces Institute of Pathology for a rotation there, and that works out very nicely. On the other hand, all that travel back and forth is expensive and temporarily relocating people and those sorts of things get to be problems, so that in many communities it is true that several different facilities participate in graduate medical education and that broadens and gives depth to the experiences. It is like at the Veterans' Hospital, as you know, there are large numbers of male patients that have certain kinds of diseases, but there is no obstetrical service in that hospital and no pediatrics. So that is a trivial example of the kinds of things that we run into in trying to have a broad range of activities.

Mr. JOHNSON. So has that relationship worked well between Eisenhower with graduate medical education and the Medical College?

Dr. WRAY. Yes. As I indicated, these things began to be in place when I was a medical student and I graduated in 1959. So we may have been close to divorce at some times, but nonetheless it has persisted over these times. [Laughter.]

Mr. JOHNSON. And if something were to happen to that relationship, how long would it take to start up a relationship again? You said this one started in 1959. Is that something that is easily movable from one place to another?

Dr. WRAY. No, not all institutions want to participate in these kinds of activities. And in the institutions that have been built, directed primarily at patient care services, a lot of times there are not suitable places for conferences and space for other kinds of people to be there other than the people that are directly involved in the care. So you get into the problem of developing facilities and a lot of the medical staff that are in another hospital may not have ever been interested particularly in medical education except, you know, in a casual way, and that does not lend itself to long-term development.

Mr. JOHNSON. Let me move to Fort Gordon and General Spaulding and Colonel Steinberg together, let me ask you about the third leg in this stool and the importance of the relationship between the Medical College and the VA and your graduate medical education program and other programs in the consolidation of services. If you could just provide a general comment about that.

Colonel STEINBERG. There has been a long relationship certainly between the three institutions, but I think there were some acute changes that occurred in the last 4 or 5 years which brought the institutions significantly closer together. I think the first of which

was a significant reduction in available funding to DOD for health care. Eisenhower was faced with some 17 percent budget cut mandated by Congress, the result of which was that we had to begin to pare down some of the things that we did or provide other ways of meeting our requirements, both our military and civilian obligations.

Fortunately, when General LaNoue, our current Surgeon General, was the Commanding General of Health Services Command, we set upon a course to develop better ways of providing good economic management in our health care delivery system. We called that the Gateway to Care Program. It has been enormously successful through the years. With that in mind, we began to embark on a new relationship with the Department of Veterans Affairs facility and with the Medical College of Georgia.

When Somalia came along, Eisenhower suddenly found itself in the position of having to deploy significant members of its surgical staff to a war zone. One key element that we lost very abruptly was our ability to provide neurosurgical care; one of the things you must remember is that Eisenhower is responsible for 1.3 million DOD beneficiaries in the southeast. Without neurosurgical care available here, there are significant numbers of people who would have been without that available service in a DOD facility. The cost to buy that on the open market would have been absolutely enormous.

We worked together with our consultant in neurosurgery from the Surgeon General's office, with Mr. Ayres and Dr. Kiernan from their staff at the Department of Veterans Affairs facility, with Dr. Allen, the Chairman of Neurosurgery at the medical school, and we put together a joint neurosurgical program using the VA as the central hub, which allowed us to continue to provide DOD neurosurgical care, support the neurosurgical training program at the College of Medicine, and support the VA facility with enhanced neurosurgical services. We simply moved our equipment to the VA Medical Center, we moved our neurosurgeon, the one that was left, to the VA and used the VA neurosurgical team and the Medical College of Georgia's neurosurgical team in concert.

The third event that occurred which brought us much closer together was the directive to reduce the force size. We were faced with a significant reduction in military personnel, and part of that reduction involved graduate medical education losses. The Army Medical Department has depended for years on our ability to provide front line medical resources through our graduate training programs. Our trained surgeons and our trained orthopedics are the ones who go to war. We do not have a selective service system in place and so we train and send to the battle line our guys, the folks that we have trained in our facilities. Reducing the numbers of graduate medical education positions in the Army forced us to begin to look at other ways of meeting these educational requirements. It became obvious to us that we had in Augusta the perfect combination to meet that demand and that combination was joining the Medical College of Georgia in its excellent educational facilities, the VA and their marvelous facility, and Eisenhower's good center, into one educational unit to meet the requirements not only now but for the years to come.

Mr. JOHNSON. One final question on a subject that is near to my heart, and that is telemedicine. That is something I have been interested in for many, many years and I want to commend the Medical College for being at the forefront of this issue, because they clearly are the leader in this country on this issue.

You have touched on it, General Spaulding and Dr. Wray, but I want to ask General Spaulding if you would explain the importance of the relationship between Fort Gordon, which as you mentioned is the Signal Corps Telecommunications Training Center, and perhaps more in the future with respect to telecommunications advances in the military. How important is it to have this continued relationship with Eisenhower being an important medical center, Fort Gordon being the most important Signal Corps training center for telecommunications and then tying that in with the importance that the Medical College has placed on this.

As you know, we were able this year, through the help of Senator Nunn, on the House side to get a million dollars in the defense budget for use in studying this very issue in the military, in the southeast, which will involve not only Fort Gordon and the Medical College, but also Georgia Tech, with the important work they are doing.

Would you comment on that, please?

General SPAULDING. Well I think the first thing is just to re-emphasize the fact of what medical technology and specifically telemedicine means to the war fighters. Our Chief of Staff has really put a big emphasis on the digitalized battlefield and has really pushed technology and what it means to a ready army.

Certainly from the medical perspective you can easily see how applications of that technology would allow us to expand and extend our medical services to remote areas. You can imagine a field or military situation where you have a field hospital that, if connected properly, through satellites and other technology with a fixed large facility, you could have consultation and you could have other immediate help to the doctors and the corpsmen out in the field taking care of a patient, without actually having a big hospital there. So you can really see how you can expand in the use of our technology. And of course in our area of the southeast where we have many, many small, isolated hospitals and clinics, again at Eisenhower, you know, using telemedicine and other advanced technology, we can do consultation and we can do other support things without actually being there. So certainly there is just an excellent opportunity for us to expand our resources using that technology.

And, of course, the situation we find ourselves in here, with Fort Gordon being the Signal Center for the Army and all of the very aggressive work in medical technology and telemedicine that has been done at the Medical College of Georgia, we are just in a perfect situation to tap in on the existing resources right here. So certainly, we are in a perfect situation to expand on that.

Mr. JOHNSON. Would you consider that situation to be relatively unique with respect to the Fort Gordon Signal Corps telecommunications training, et cetera, with the connection with the Medical College here and——

General SPAULDING. I would say that. I think the idea of medical technology and expanding that though will not be just unique here.

I think that is going to be adopted by the Army in general, and I am sure when our Surgeon General stands up—he is interested in spreading that to every unit.

Mr. JOHNSON. Certainly, but the embryo is here.

General SPAULDING. The embryo definitely is here.

Mr. JOHNSON. Thank you.

Dr. Rowland.

Dr. ROWLAND. Thank you very much, Congressman Johnson.

I want to follow up on the telemedicine thing because I tell my colleagues in the Congress who have some telemedicine in their states, and they are really astounded to know how far ahead we are here—Georgia is so much out in front of all the other states in dealing with that. I have had an opportunity to talk with Dr. Tedesco and I believe, Charlie, you all are planning on establishing eight centers around the State with satellite primary care centers, and everything is pretty well in place and ready to go forward with that, is that correct?

Dr. WRAY. This year, there will be a very noticeable change in that there are hubs in the various regional medical hospitals and their associated smaller hospitals, so that essentially there will be a hub with about four sites around each hub, and that will allow this kind of communication between the hospitals and the hospitals that they are related to. So we hope that that will enhance the local areas. I think the public has not seen very much of this yet in that it was not in their community, but this year I believe that they will. And we will connect the medical school here and Emory into this system, so that the whole State will be covered.

Dr. ROWLAND. It seems to me, General Spaulding, that this is a perfect laboratory here in the State of Georgia, with the relationship between Eisenhower and the Medical College and the VA here, to demonstrate how effective it will be, as you have already pointed out, in doing many of the things that have to be done in the Department of Defense.

General SPAULDING. Yes, sir.

Dr. ROWLAND. So I am really pleased to know that we are so far out in front here, and hope that this relationship will continue to develop and will be beneficial to everybody.

Let me ask you this—I have long argued and been involved in trying to demonstrate the cost effectiveness of the sharing agreements between DOD and the VA over the years, and how well it worked where there are affiliated hospitals as well. I have been challenged on that issue by some who say that it is not that cost effective. I would sort of like to have your comments about how cost effective are these sharing agreements that we are putting in place now?

Colonel STEINBERG. If I might interject, Dr. Rowland, let me give you a couple of examples of how these things work to the benefit of all of us financially. Supposing we had a patient who had a brain tumor and needed a neurosurgical operation, and we use neurosurgery as an example. The absolute cost in terms of having to buy that operation on the outside would involve a cost for the physicians, some $3,000 to $4,000 for his services, the anesthesiologist's cost of probably $700, $800 to $1,000, the pathologist's cost, the laboratory service cost, the inpatient hospital cost. You are looking

at a bill of probably $15,000 to $20,000 for this procedure. When you do not have to buy one piece of that, you significantly reduce the cost. And the more efficient you are, the more cases you do, the lower your per capita costs are in terms of providing that service.

What we have done, by working jointly, with the Department of Veterans Affairs Medical Center and the Medical School, is to provide a service that maximizes these providers to the extent that we are able to share beds, reduce in-bed day costs, share providers, reducing the absolute cost so that as you look at the true dollar value of a neurosurgical procedure, we can probably provide that at about 70 percent of the current market price. And that is a pretty significant amount in terms of reducing costs.

One of the other areas where we have looked at cost reduction has been using our MRI scanner. We have a sophisticated scanner at Eisenhower that cost in excess of a million dollars to install. The Department of Veterans Affairs Medical Center provides the staff to run the unit. The capital dollar expenditure was not made at the Department of Veterans Affairs Medical Center to buy that equipment, which saved the government significant dollars. We have two facilities that use the same equipment, shared the same capital cost and the same staff. The savings are obvious, I think.

This is repeated over and over again.

The issue of women's health is another area that I think has a great opportunity for us to work together to reduce costs. The Department of Veterans Affairs Medical Center does not have the need for gynecologic care right now, except in the broader sense, to provide women's health support services for female veterans. Eisenhower has a very large women's health unit. Why not combine those two and avoid the requirement of the Department of Veterans Affairs to have to go out and buy those services. We certainly have the capability in our own house to absorb what their requirement is. The reduction in cost to the VA, if they had to go out and buy that service, I think would be substantial.

There are many similar areas where we have worked together to try and bring these costs into toe, and I think the future affords us the opportunity to do even more.

Dr. KIERNAN. I have two other examples I would like to bring forward.

We have a sharing agreement with the Medical College of Georgia for cardio-thoracic surgical services. We figure that with that sharing agreement, we are able to do coronary bypass surgery on a patient for about $12,000. From time to time, we have to send a patient out into the community because of one thing or the other—that is rare, thank goodness—but when we do that, it costs us $20,000 to $30,000 for the same sort of operation.

We also have a sharing agreement with Eisenhower for specialized laboratory work. And we found, again through experience, that if we were to send that laboratory work out to a private laboratory, that it would cost us almost another half or another times more than it does through Eisenhower Army Medical Center. And we also have very prompt response with laboratory values, being so close to Eisenhower.

Dr. ROWLAND. You mentioned women's issues as being one of the things that—and, of course, the VA not having a large number of

female patients over the years because we have not had that many veterans, we recently have had some legislation in Congress to try to address that very thing. There would have to be a good bit of contracting out in order to be sure that quality care was provided. And I think the sharing agreement that you point out would really work well in that respect.

Mr. Ayres, let me ask you, to successfully compete under any national health care reform, it seems to me that VA center directors have got to have some flexibility. I have long contended that there should be more flexibility at the local level to meet circumstances that might exist in one area and not exist in another area. Would you comment on how critical this flexibility is for you to work well and efficiently?

Mr. AYRES. Mr. Chairman, I had recently the pleasure of serving on a national task force convened by Secretary Brown to develop, in a 4-week period of time, the reform of the VA. There were approximately 200 people selected by the Secretary to accomplish this task in order for us to be a competitive health care model. For example, during fiscal year 1993, 49 percent of our inpatient and 87 percent of our outpatient work load at Augusta is mandated work load, service-connected veterans, which is separate from what any national health care plan that might come out may voucher veterans into a system where they can go where they wish to enroll in a plan.

My suggestion to you is to relieve the medical center directors of the bureaucracy that has been created over the last 40 years and allow us to operate in a franchise type situation, giving us the flexibility to manage and compete in a local environment with the kinds of alliances that we have described here this morning. And I think the Veterans Health Administration will continue to grow, serve its nation as it was intended and be more cost effective. But we must be relieved, and I think the Secretary will be receptive to that, even though the report is embargoed. That kind of direction, and Mr. Gore's reinvention of the government, which he has published, certainly will go a long way in relieving us of the constraints of OPM and OMB, and allow us to fly our hospitals in the way that I think they should be managed.

While this sounds very simplistic with regard to a complex problem, I think it is in our grasp to get relief from these constraints, and I envision a much better Department of Veterans Affairs in the health care arena if we are able to do this.

Your support would certainly be encouraged.

Dr. ROWLAND. I agree with you, I think it is very important that that flexibility exist, because if it does not, then you certainly may be hampered in the quality of services that you might otherwise be able to provide.

General Spaulding, have you signed off on this proposed VA/DOD joint sharing agreement at this time? Tell me what is the status of the agreement that exists at this particular point.

Colonel STEINBERG. We have had in place for several years a signed shared agreement. We expanded this agreement after the last public law became law in December of 1992, to include the current services that we have now. It involves the laboratory service agreement, the scanning agreement, the neurosurgical agreement

and residency training agreements in family practice, psychiatry and in surgery to accommodate the neurosurgical service move. We would like to expand these services significantly by expanding our DOD sharing agreements. Those are under discussion at the present time.

What we usually do, Dr. Rowland, is as we complete a service and add it to the portfolio of things that we do jointly, we amend the current agreement that we have in place. We are adding to what was initially a very complex and difficult agreement to understand, based on old public law, and are amending that to meet the constraints of the new public law of 1992.

Dr. ROWLAND. Is there some further action required by DOD before you can get the agreements in place?

Colonel STEINBERG. There are always people who are nervous about innovation.

Dr. ROWLAND. Yes. [Laughter.]

Colonel STEINBERG. If I might be so bold as to say, the thing that has sort of kept us on track is the fact that in our hearts we know that what we are doing is economically sound and it is right for our patients, and we know—at least most of us feel that we know that our leadership in the Army supports these efforts.

There are some areas where we need relief. We need to be able to follow the intent of the public law. And I will give you a good example, when the law became public in December of 1992, it was actually signed by the President I think in late December of 1992, what the law simply said was that the commanders of medical centers and VA Medical Centers—DOD and VA—had the right, under the law, to negotiate whatever agreements were mutually beneficial for their patients. It was a very simple law. It was the intent of Congress, as most of us understood that, to make sense out of shared services, to allow facilities who lived in the same town to share the same doctors and the same hardware and not spend twice the government money to do the same thing. Very simple law, made a lot of sense.

Well as you know, once the law is public, the rulemakers get involved and one of the things that has hampered our ability to relate has been the fact that the rulemakers have not done anything with the law. And I will leave it at that. [Laughter.]

Dr. ROWLAND. And I will try to pick it up there. [Laughter.]

And see what we might be able to do, my colleague and I, to deal with that, because as you point out in Title II, we have had that sharing agreement, the waivers in place, for VA and DOD to move forward with that. So we will see what we can do. I just wanted to kind of bring that out here so we would have it on the record.

Colonel STEINBERG. I wanted to add one other thing, if I might, on one of Dr. Wray's earlier comments. We want to work together as three institutions, that is obvious. I mean, we are all here together, we have put our lives and our professions on the line to make this thing happen. It is important to us because it is good for the country, it is good for Georgia, it makes sense.

But there are some things that we specifically need relief from. When a faculty member from the Medical College of Georgia comes to Eisenhower to support us in the operating room or to help do a case or to give a lecture, he is covered under his tort program

from the State. When I send a faculty member to the Medical College of Georgia to scrub on a case, to attend on OB, for example, to give a lecture, the Federal Tort Relief Act does not provide us that umbrella of coverage when we interact with a civilian beneficiary. Even though part of the duties of our military physician involve the service he then provides. What we need is an enlargement, if you will, of the umbrella that the Gonzalez Act has provided, so that when our doctors, as part of their regular duties, have to attend, in an educational sense, at the medical school that that umbrella of coverage will extend to them at that facility.

Dr. ROWLAND. So when a doctor comes to the Medical College here from Eisenhower, he is not covered by, or she is not covered by the Federal Tort Claims Act?

Colonel STEINBERG. That is correct.

Dr. ROWLAND. Is what you are saying.

Colonel STEINBERG. That is correct.

Dr. ROWLAND. Would that individual be covered if the patient, for example, were receiving Medicare?

Colonel STEINBERG. No, they would not. They would only be covered if the beneficiary was a specific DOD beneficiary.

Dr. ROWLAND. I see.

Colonel STEINBERG. And what we need relief from is, you know, we cannot simply send our physician there and have him attend only on DOD beneficiaries because we do not put labels on our patients when we share facilities.

Dr. ROWLAND. Right.

Colonel STEINBERG. And we simply need the relief when he works as part of his regular duties at the medical school, to attend on those services.

Dr. ROWLAND. Those are the kinds of details that we need to bring out in a hearing like this, so that we will know what we need to do in order to meet those. I am sure there must be some other things. I would look forward to getting some additional information from all of you about what needs to be done in order to address the kind of specific problem that you have just mentioned.

I would like to ask some more questions, but our time—we have been here for an hour and 15 minutes and you have been very patient, and I appreciate that. There are some questions that we will submit to you all for the record and we would be very pleased if you would answer those.

Thank all of you very much for coming this morning.

Our second panel is Lieutenant General LaNoue, who is the Surgeon General of the U.S. Army; Ken Cox, Director of Operations and Management Support Office, Health Services Operations, Department of Defense, and Arthur S. Hamerschlag, Director of the Medical Sharing Office, Veterans Health Administration, Department of Veterans Affairs. Gentlemen, thank you very much for being here this morning.

I have not really enforced the 5-minute rule here, but if you would kind of look at the 5-minute rule, I would appreciate it, and you may proceed as you are so inclined, and we will call on General LaNoue first.

STATEMENTS OF LT. GEN. ALCIDE M. LANOUE, SURGEON GENERAL, U.S. ARMY; KENNETH E. COX, DIRECTOR, OPERATIONS AND MANAGEMENT SUPPORT OFFICE, HEALTH SERVICES OPERATIONS, DEPARTMENT OF DEFENSE and ARTHUR S. HAMERSCHLAG, DIRECTOR, MEDICAL SHARING OFFICE, VETERANS HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF LT. GEN. ALCIDE M. LANOUE

General LANOUE. Mr. Chairman, thank you very much. I do not have a prepared statement. I was told yesterday afternoon that I was invited, and it took me 2 seconds to decide that I wanted to come here and support your hearing, and to support Eisenhower Medical Center as part of this great consortium that has been generated over time here in Augusta.

I am here to tell you that Eisenhower is a very valued component of the Army Medical Department. The Army Medical Department is a world class agency. The United States needs it, and the roots and the core of what the AMEDD has become over the years comes from its graduate medical education programs. Eisenhower Medical Center, because of the consortial relationship with the Medical College of Georgia and the Veterans' Aministration here in Augusta, demonstrates that core capacity of the Army Medical Department.

We are facing some very severe constraints both in terms of budget and manpower, as we re-engineer and redesign our force, and I am at risk of having to give up more and more graduate medical education programs. I am told there are members, perhaps in Congress, peers of yourself, that are considering taking down what is viewed to be infrastructure of the Federal Government which includes our medical centers, such as Eisenhower. I am here to tell you that Eisenhower is a valued component of the Army Medical Department, and that I need to campaign vigorously to keep graduate medical education and Eisenhower Medical Center as it is, as a component of the Army Medical Department in the future.

Thank you.

Dr. ROWLAND. Thank you.

Mr. Cox.

STATEMENT OF KENNETH E. COX

Mr. COX. Mr. Chairman, good morning.

As the Director of Operations and Management Support in the Office of the Assistant Secretary of Defense for Health Affairs, one of my most important responsibilities involves the development and oversight of resource sharing policy with other Federal agencies.

The Department is particularly pleased to have the opportunity once again to express its position on health care resources sharing between DOD and VA. The Department places enormous value on its sharing partnership with the Department of Veterans Affairs. As an indication of the success of our mutual relationship, during fiscal year 1993, there were approximately 600 sharing agreements in effect, representing more than 3,000 shared services. Due to the great combined size and resources of the VA and DOD medical systems, as well as our geographic dispersion, there are many opportunities for sharing resources and saving Federal dollars. More

than ever before, sharing among Federal health care providers is relevant and necessary to support the cost-effective—and those were your words earlier—delivery of quality health care for Federal beneficiaries.

The primary initiative within the military health services system today is to position itself for national health care reform through implementation of managed care health care delivery on a regional basis, a program that we in the department are calling TRICARE. This program will enable us to be responsive to the needs of patients who are better informed, have higher expectations and are more resourceful in obtaining services than in the past. We must be prepared to provide access to care in a most cost-effective manner with no degradation in the quality of that care. Within each region under this model, a lead agent, Eisenhower for example, has primary responsibility for health care delivery throughout that region. The lead agent will coordinate the planning, build integrated health care networks, and serve as a referral agent for a broad system of care within the geographic region. For the first time, beneficiaries living outside of the immediate area surrounding a military facility will have a responsible organization to assist in meeting their health care needs.

In DOD, we clearly see the potential for increased roles for VA in this environment. In areas not served by a DOD medical treatment facility, VA may offer cost-effective care for selected services on a space available basis. Initial contact, negotiations and ongoing interaction will be facilitated by the existence of a local DOD lead agent for each regional area. Significantly, due to increasing base closures, the number of such geographic areas not served by DOD medical treatment facilities is growing. VA/DOD sharing will continue and in fact will be integral to the managed health care delivery system which the Department of Defense is implementing.

The VA and DOD have wholeheartedly entered into the spirit of the 1982 sharing legislation. The program has shown continued annual growth. In 1984, there were 102 combined VA and DOD facilities with sharing agreements. That number grew to 332 in fiscal year 1993. Over 140 VA facilities have operating agreements with 191 military medical facilities and other medical commands. In fiscal year 1993, there were approximately 3,500 services shared, a 10 percent increase over the previous year, and I expect the program to continue to grow. The types of services covered by sharing agreements, we have had some examples of this morning, and they range from major medical and surgical procedures to laundry, blood and laboratory services, and to unusual specialty care services. In fiscal year 1988, VA/DOD sharing resulted in an estimated cost savings of $9 million, growing to almost $15 million in fiscal year 1992.

Education and training agreements between the departments increased in fiscal year 1993 from 182 to 215. These agreements typically involve an opportunity for training in return for enhanced staffing and are between VA Medical Center and reserve component units, for example. Under the typical agreement, a VA Medical Center provides space for weekend training drills. In return, reserve personnel serve as supplemental staff. For an example, the VA Medical Center in Tampa, Florida has training agreements

with Army, Navy and Air Force reserve units. An average of 25 reservists train at Tampa on weekends while simultaneously supplementing VA staff. Reservist training at Tampa include physicians, nurses and medical technicians. Training occurs in medical services, shock trauma, aeromedical evacuation, disaster preparedness, surgery, psychiatry, pathology and administrative services.

The national Defense Authorization Act of fiscal year 1990 authorized DOD to reimburse VA Medical Centers for services provided to the Civilian Health and Medical Program of the Uniformed Services, we call CHAMPUS, beneficiaries. Subsequently, the Veterans Health Care Act of 1992 expanded the sharing authority and further clarified VA authority to treat CHAMPUS beneficiaries. A memorandum of understanding facilitating implementation of these laws was signed by the Secretary of Defense on February 3 of this year. The first sharing agreement under the MOU has been negotiated with Asheville, North Carolina VA Medical Center.

A major area is VA/DOD sharing joint venture construction of health care facilities. Where it is in the best interests of the government, the VA and DOD have been working together to develop joint ventures. The first fully operational joint venture is the facility at Kirtland Air Force Base in Albuquerque, New Mexico. This is a joint undertaking of which all can be proud. The Air Force is operating a wing in the Albuquerque VA Medical Center. The Air Force also operates a comprehensive health care clinic and dental clinic adjacent to the hospital. Through this sharing effort, the Air Force avoided approximately $10 million in construction costs and is producing additional savings through multiple sharing agreements within the facility.

Another first is a new 129-bed hospital under design at Nellis Air Force Base. The $75 million fiscal year 1990 Federal medical facility built to replace the Nellis Air Force Base Hospital is near completion. Opening is scheduled for July of this year, 1994. Air Force will operate the 129-bed facility, but VA will staff its 52 beds. VA will continue to operate its Las Vegas outpatient facility. The Air Force and the VA project estimated annual savings of almost $24 million and $7 million respectively. Joint ventures are also being evaluated at the following locations: At Travis Air Force Base in California; Elmendorf Air Force Base, Alaska; East Central Florida; Fort Sill, Oklahoma; Fort Bliss, Texas; Tripler Army Medical Center in Honolulu; and Goodfellow Air Force Base in San Angelo, Texas. Early identification of requirements and planning for health information sharing at joint venture sites is an area of particular importance, and the departments are currently developing an approach to evaluate business processes at joint venture sites.

VA and DOD collaborate in numerous research projects. In fiscal year 1993, investigations included research in traumatic brain injury, post-traumatic stress disorder, alcoholism, AIDS, spinal cord injury and sensory impairments. This program complements the research programs of the two departments. This fiscal year, $20 million was appropriated for cooperative medical research and the mystery illness among veterans of the Persian Gulf War is a priority research area.

The DOD health care community recognizes that it must develop creative and innovative approaches to health care delivery while retaining the flexibility to respond to the demands of its readiness mission and health care reform. In that light, DOD is already collaborating with VA in pursuing new sharing models to assist each department in serving its beneficiaries in a rapidly changing health care environment.

This concludes my statement.

Dr. ROWLAND. Thank you very much.

Mr. Hamerschlag.

[The prepared statement of Mr. Cox appears on p. 62.]

STATEMENT OF ARTHUR S. HAMERSCHLAG

Mr. HAMERSCHLAG. Thank you, Mr. Chairman. Let me tell you how happy I am to be here today to appear before the Committee. It is a real pleasure to be with you again.

As Director of the Medical Sharing Office, I have policy and oversight responsibilities for VA sharing programs. These authorities are designed to enable the VA to improve the quality and availability of services it provides to veterans, save VA and DOD money by allowing them to buy services from and sell services to each other, and allow VA to earn dollars by sharing medical resources with our affiliates and other health care providers. VA endorses these worthy objectives and has made good use of these authorities over the years.

My job in Washington is to provide policy guidance, oversight, technical assistance and encouragement of VA Medical Centers who then decide how and when to use these authorities. Expressed another way, we try to put a sharp tool in the hands of local managers and they decide how best to use it. Augusta VA Medical Center provides an excellent example of how these tools can be used with DOD and our affiliated medical schools. And let me add, I strongly support what the VA Medical Center is doing here with DOD and the Medical College. We think it is great.

From a national perspective, VA and DOD have approximately 600 active sharing agreements covering some 3,500 shared services—and we have talked about the types of services those might be.

VA has approximately 246 specialized medical resources sharing agreements in place. And again, typical services might be radiation therapy, MRI, CT scans, mammography, cardiology and so on. Examples of services VA provides under this authority include diagnostic radiology, clinical lab services and so on. In many cases, a VA Medical Center might buy one set of services from its affiliated medical school and sell a different set of services to the school. To the extent that these payments offset each other, out-of-pocket expenses are limited for each partner. I think importantly in a case like Georgia and rural areas, this authority allows VA Medical Centers to share their expertise and excess capacity with other local providers and to the general benefit of health care in the area.

Mr. Chairman, up to this point, I have focused on how these authorities are being used at the present time. You have requested that we address how these authorities might be used in the future as we go into health care reform.

Secretary Brown has laid out a clear, challenging vision for the future of veterans' health care. Under President Clinton's Health Care Security Act and perhaps your act as well, all veterans and their families would be able to enroll in the VA health care plan. At the same time, veterans would be free to choose other providers of care. VA would compete in the marketplace, like other health care systems, on the basis of quality, cost and accessibility. It is an exciting and challenging vision for the VA and one we are thinking about very heavily.

In this environment, VA will need every possible tool to hold down costs, to maximize income, attain the highest possible quality of care and provide the greatest possible access to its services. In this most demanding future, I believe VA sharing programs will be essential tools for our local health care managers.

With your permission, I would like to offer a brief example. Suppose a VA Medical Center and a DOD medical treatment facility are closely located, like they are here in Augusta. The two facilities might agree on various levels of cooperation under health care reform. One approach might be to establish separate health care plans for their beneficiaries, but to set up a single network of clinics available to members of both plans. The two facilities might then decide to jointly plan their specialty care and sell services back and forth, just like we are talking about doing here today. For example, one facility might provide all specialty pediatric care, another might provide open-heart surgery. The nature and degree of cooperation could vary widely, depending on local circumstances. But I think what is important—what is really important—is that our local health care managers have the ability and the freedom to make those sorts of decisions based on local conditions.

Of course, many VA Medical Centers are affiliated with medical schools which are integral parts of our current health care system. The medical schools themselves might want to set up their own health care plans or participate in ours. And again, I think VA Medical Centers must have the ability to work with their affiliates in a wide range of innovative ways, perhaps in ways none of us can even foresee right now.

In summary, Mr. Chairman, VA's sharing programs are important tools which we use to carry out our mission of providing high quality health care to America's veterans today, and we envision doing that tomorrow as well.

Thank you very much, and I will be happy to answer any questions you might have.

[The prepared statement of Mr. Hamerschlag appears on p. 66.]

Dr. ROWLAND. Thank you, Mr. Hamerschlag, Mr. Cox. And General LeNoue, I really do appreciate you being here very much. And I do not think you needed a written statement, I think you put it very succinctly and I really appreciate the strong statement that you made.

General LANOUE. Thank you.

Dr. ROWLAND. Mr. Johnson.

Mr. JOHNSON. Thank you, Dr. Rowland.

General LaNoue, I also want to thank you for coming down and participating, and welcome you back to this area. As I understand it, you know Eisenhower very well, having been the former Com-

mander there. And we appreciate your insight into the use of that knowledge.

Let me ask you, is the Army planning to restructure the system of medical centers? And if so, how will that affect Eisenhower? I know you touched on that a little bit in your opening statement, but if you could elaborate on it.

General LANOUE. The Army is going through a major reorganization of the Army Medical Department, which was begun by a task force that I put together a little over a year ago called Task Force Aesculapius, to borrow from my ancient Greek history in medicine. Under Task Force Aesculapius' proposal, we retain all of our medical centers, because as I explained, they are the core of what we do. Further, each medical center becomes a regional command we are calling Health Service Support Areas. They happen to fit very nicely with the major new concept that the Assistant Secretary of Defense for Health Affairs has put together, which he calls lead agents. So it snuggles up to that very well. It allows a recognition in Department of the Army that health care and the practice of medicine is a local business and that local flexibility and local design is very, very important and that centralized management tends to break down efficiency. And so by giving the Commanding General here at Eisenhower responsibility for all Army structures in his region, it gives him greater authority and puts him closer to where the real action is.

So that reorganization, in my view, will strengthen and preserve our medical centers, to include Eisenhower Medical Center.

Now unfortunately, along with this reorganization, we have some bills to pay. By that I mean we have a smaller budget on a per capita basis coming to us each year over the next 2 years at least, and we also have a reduction of military manpower. Now in our business case, where we are allowing our hospital commanders to run the business, there are CHAMPUS funds available as well as the funds for direct health care support. By putting those together in the catchment area and running it more efficiently, the hospital commander can hire more civilians or contract with more contractors to make up the difference in the loss of military manpower. Again, that comes back to why the consortium here is so valuable. And as Colonel Steinberg so eloquently pointed out, during Desert Storm/Desert Shield, that consortium of manpower and contract relationships here supported Eisenhower when they had a significant loss of manpower—physicians, nurses and technicians who left.

And so we build on that capability to have more contractors, more civilians working with fewer and fewer military. Because the business supports it, because there are enough beneficiaries here to support Eisenhower Medical Center as an institution. And even though we do not have the military manpower to do 100 percent of the work, the consortium and the business of the health service support area can be sustained which gives us a readiness posture that we otherwise would not have if somebody were to close Eisenhower.

Mr. JOHNSON. So is Eisenhower the only facility of its kind in the southeast?

General LANOUE. The closest to the south and west would be Keesler Air Force Base in Louisiana and to the north would be Fort Bragg and then the Navy at Portsmouth.

Mr. JOHNSON. On that subject, what is the possibility of consolidating, say for example, some graduate programs, to bring in Air Force, Navy doctors for graduate training here? Is that a possibility?

General LANOUE. Yes, sir, that is a possibility that makes sense to me.

Mr. JOHNSON. Where are the patients, from Georgia, North Carolina, South Carolina and Alabama referred?

General LANOUE. There are a variety of patterns. Because Eisenhower has been here since about 1974 as a medical center, the Army medical activities in the States you mentioned have developed a relationship with the staff at Eisenhower, and patients are referred from Alabama, as far away as Tennessee, where Fort Campbell is, and particularly Fort Stewart and Fort Benning in the State of Georgia, and of course Fort Jackson is so close to us in South Carolina. So there is a regular flow of patients on a consultative basis coming from those primary care areas into the tertiary care area of Eisenhower.

Mr. JOHNSON. Under what conditions are these patients sent to Walter Reed Army Medical Center?

General LANOUE. Well Walter Reed has a global posture. If you think of Eisenhower as having tertiary care, places like Walter Hall in the Air Force and Walter Reed in the Army, have a global relationship. And by global, I mean it is sort of a quaternary as opposed to tertiary level of care and that is the capability to do the most special kinds of things. The Armed Forces Institute of Pathology, for instance, is on the same lot that Walter Reed is on. They have a pathology experience that is second to none in the whole world. And so very unusual, very demanding diagnostic cases in oncology frequently get referred from around the world to Walter Reed. You go to Walter Hall, and it is the only Department of Defense institution that does liver transplants. So there is that kind of special relationship at those institutions.

Mr. JOHNSON. In the event that the Defense Base Closure and Realignment Commission, the BRAC Commission, closes some bases say in Georgia, North Carolina, South Carolina and Alabama area, is it possible that Eisenhower could take on additional workload to pick up the slack that is caused by that?

General LANOUE. That is possible. We would have to set up a model to see just what the circumstances were. Of course, if a base were to close, the active duty component and their family members would depart the area. The question would be how many of the retirees who have moved to that location because of the support from the hospital and the installation would be there and would flow towards us. There is no doubt in my mind that they would flow this way, since when I was here in 1984–1986, we frequently had patients coming up from the southern part of Florida to come to Eisenhower Medical Center. It surprised me, but they did it on a regular basis.

Mr. JOHNSON. On the consolidation of services aspect, you have touched on that and we have had a lot of discussion about that.

How important do you see that in relationship with Eisenhower being where it is, so closely connected to the Medical College of Georgia as well as this major VA Center here—how important is that in Eisenhower's future?

General LANOUE. Sir, I think it is essential. By wrapping the futures of the three installations together, the sum is greater than the parts, there is no doubt about that. When you ask questions about how much money is saved, so many things happen that cannot be added up in terms of real dollars when you see the flow of the professionals and the training that moves between the institutions. The contribution of telemedicine that has been referred to is going to have an immense impact on the future design of health care. And by having the graduate medical education foundation brought to the highest character in terms of quality and survivability of each program, which can be done by joining together the three services, and the different kinds of patients that the three hospitals attract just makes for a mature program that will withstand any accrediting body.

Mr. JOHNSON. Let me just close with you with a follow up on the telemedicine issue. Do you see Fort Gordon as being in a unique situation because of its telecommunications/Signal Corps training programs and with the connection with the Medical College of Georgia, which is widely recognized as at the very forefront of this issue?

General LANOUE. Yes, sir it is unique. Joining a center of excellence for medical education here in the Augusta area, which includes Eisenhower, and having the command which is a center of excellence for communication—putting those together, I think is going to have as dramatic a change in the design of the delivery of health care as will the current debate in the President's proposed program in terms of redesigning. If there are three revolutions going to take place, one revolution took place when Medicare came on line. The second revolution is being debated on the Hill now. The next revolution as to how we practice medicine is going to be telecommunications. The folks that are in the need in that will benefit from it first and be the pioneers of it. And you have that capability here.

Mr. JOHNSON. Thank you, General.

Let me ask Mr. Hamerschlag a question or two. Under the administration's proposed staffing reductions in the Veterans Health Administration over the next 5 years, in your opinion, do these reductions—will they have an impact on these sharing agreements, or creating new sharing agreements and maintaining existing ones?

Mr. HAMERSCHLAG. I think it is very possible they could. I have talked to a number of directors from VA Medical Centers across the country on an anecdotal basis, and they have given me stories like these—gee, we have a great laundry here and we put on a second shift and we do laundry for the DOD facility down the road. We make money, they save money, it is a beneficial relationship. The concern is they get FTE cuts and they are going to have to look at what their core business is. They are going to provide services to veterans first and if that means they have to reduce staff, they might well decide to lay off the second shift that has come on just

to do DOD work load, in order to maintain services elsewhere. That would be a real shame, because in those sorts of examples, we are saving the Federal Government significant amounts of money and that is not an asset or a program we would want to lose.

Mr. JOHNSON. And a follow up question on the proposed health care reform. As I understand it, the VA would be free to offer its services to all veterans and their families. Does this mean that the Secretary will allow dependents to receive treatment in VA facilities? And how do you see that working out?

Mr. HAMERSCHLAG. What the Secretary has said is that he certainly encourages VA to offer its services under health care reform to veterans and their families. What he has simply said is until we know how many veterans themselves will enroll for care and what that workload is, he wants to ensure that veterans themselves have first crack at our facilities or our beds. Assuming that we are not overwhelmed, but in fact we have capacity, we could go ahead and treat dependents directly. If on the other hand, we have more work than we can handle, then we need to contract with other folks to provide that workload, and in those cases we might contract for care for dependents. But that is going to be a local decision, I think, based on a supply and demand kind of situation.

If I could clarify one thing along those lines. There has been some concern about whether that inhibits our ability to provide care to DOD dependents for right now, and the Secretary has made it very clear that does not, that DOD is part of the family and if we can come up with an arrangement here in Georgia or anywhere else to provide care to DOD dependents or CHAMPUS beneficiaries, we can certainly do that.

Mr. JOHNSON. And also the President has proposed, I believe, that the VA continue under—or Veterans' Hospitals continue but compete with other plans. How do you see—I had a long discussion about this yesterday with Tom Ayres, and I am very confident that he can handle the competition, but how do you see it in general?

Mr. HAMERSCHLAG. Well I think that is a good question. I think competition is a good thing and I think it will force VA Medical Centers to be high quality, low cost health care providers. If there are medical centers that are unable to meet that challenge and veterans simply do not enroll, I think they will be telling us and others that they are not interested in getting their care from that health care center. I hope that will not be a frequent case and maybe not a case at all, but if it does happen, then I think the VA has to look at whether that facility can be improved or really needs to have a mission change or something like that. But that is the downside, that is what we are concerned about, what we are working very hard not to let happen.

Mr. JOHNSON. Thank you very much.

Dr. ROWLAND. I want to pursue the question that Congressman Johnson asked about reduction in staffing in the VA and what is going to be taking place over the next 5 years, and I was listening to what General LaNoue said about this consortium here, as an example of how quality care and access to care can continue, even while some downsizing of the military takes place. Those budget constraints that are out there certainly place the VA in a bind as well. It seems to me that it would work both ways, that if there

was some staffing—you mentioned the laundry, which was an example of what might happen that might be adverse, but what about professional people and the professional services that were provided. Would it not work the same way for the VA that it would for the military, the downsizing of the sharing agreement? Could we expand on that a little bit?

Mr. HAMERSCHLAG. Well it would seem to me that the opportunity to share services is a way to absorb cuts without reducing care. If you have two separate cardiology programs and can combine those, you probably can come up with savings—maintain that same quality of service and perhaps put fewer resources into a combined program. But I think there is a limit to what you can do there. If you pull enough resources out of any facility or group of facilities like you have down here, at some point it is going to have to affect the type of services that can be provided.

General LANOUE. Sir, part of what we need to do is to borrow from the business community incentives of running a good business and try to squash some of the bureaucratic rules and regulations that we have. For instance, as the Federal Government starts to look at the numbers of Federal employees, some senior manager along the way will say well we will have to institute a hiring freeze. Now at any one of our institutions here in Augusta, they may have just lost a cardiologist or an x ray tech, and they need to go out into the marketplace labor pool and find one. With a hiring freeze, you are denied the opportunity to do that. So the businessman downtown then has the advantage over you. He can then sell you the service because he can hire anybody he wants to if it makes good business sense. So we need to develop the incentives, such as capitation funding for our installations, that says if you can take care of your patients at $2,000 per person and you have got 100,000 folks there, then within that budget you can do whatever is smart. And I have found that our hospital commanders and their staffs—a great example are the two gentlemen right behind me at Eisenhower—are innovative, have found ways to save money, and have found ways to provide increased quality and access and reduce the cost. And that is the key to good business.

Dr. ROWLAND. What you are saying brings to mind the situation we had in the Department of Veterans Affairs Hospital Health Care System for a number of years, where the local directors were not given—they had a ceiling on the amount they could pay an individual. And so they had to contract out for those services that cost far more to contract out because of that inflexibility that was there. I certainly agree with you that there needs to be a lot of flexibility so that innovative things in a specific area can work.

I would certainly look forward, you know, to you keeping in touch with us and letting us know what we need to do in order to deal with that bureaucracy that creates that exact situation.

I am concerned about the Army's graduate medical education program and the threat that may be there. I think that that is one of the best things going for the Department of Defense and for the VA and the relationship that you have there.

Do you know what the Army's long-term plans for the graduate medical education program is?

General LANOUE. Well, sir, our long-term plans are based on the long-term plans directed to us from Congress and from the Department of Defense. As you may know, the Uniformed Services University of Health Sciences, our school in Washington, DC, located at Bethesda, has been tapped as being part of that infrastructure that needs to be eliminated. And I feel that that is the beginning of a long train that says we will close the medical school and then we will reduce graduate medical education and then tertiary care centers can be closed, because after all, the civilian communities have graduate medical education and a number of civilian tertiary care centers. The decision to make or buy, which is the current term being used, why do you not buy it instead of making it and depend on the civilian community.

I think you know that the civilian community cannot move very quickly to Saudi Arabia and support a war event, nor can it move quickly in the event that we have rangers being shot up in a place such as Mogadishu. So it does take a readiness posture and the readiness posture in the Department of the Army resides around graduate medical education.

We can reduce it over time, such as we granted Eisenhower permission to bring on board two civilians into the internal medicine program, so that the internal medicine program, with the reduction forced upon them, would not disappear, because GME programs resemble a house of cards, a very tenuous situation, where the interrelationship between programs in a tertiary care facility must be there to mutually support each other. You take one away and then the residency review committee will come by and discredit your next program and then that will disappear and then the whole thing will fold in on itself.

We have been asking to maintain the flexibility so that each commander, General Spaulding here, can look at the character of the quality of care which revolves around graduate medical education and preserve it. And that preservation includes the relationship with the Medical College of Georgia and the Department of Veterans Affairs. So he needs that flexibility, number one, and we need to be allowed to take down the numbers based on what we think the future size of the Army is going to be. And I am afraid that there will be some senior managers who will say the infrastructure needs to be taken down, not relevant to the future of the Army, but just trying to save money somehow or reduce the structure for some unknown reason on my part.

Dr. ROWLAND. You mentioned the Armed Forces Medical School there and the threat that exists now. Tell us a little bit about the commitment that students make that go there. What is their long-term commitment and how is it beneficial to continue to operate that school?

General LANOUE. Okay, I will attempt to answer that question, but behind me is Dr. Cassimatis, who is my staff person who runs graduate medical education for the Army——

Dr. ROWLAND. Would you like him to come up?

General LANOUE. Sure. Dr. Cassimatis.

Well why do I not just let him answer that question then, since he knows it better than I do.

Dr. CASSIMATIS. Yes, sir, the students at USUHS have a 7-year commitment, but of course by the time they have completed their graduate medical education, they are usually on active duty at least 11 years, four for graduate medical education and seven payback, before they have the option to get out. And given that in another 9 years, they could reach the 20 year point, there is a great incentive for them to stay in.

More important than that though is not the obligation that they have, but I think the point of view and the perspective that they develop while they are at USUHS. Even though we get very fine physicians out of the health professional scholarship program, the students of USUHS are I think imbued very early on with the unique perspective of military medicine, and, for example, many of them elect to participate in airborne or air assault training. They participate in medical exercises and they develop an appreciation for our soldiers and for what I think our colleagues in all the other branches live with every day. As a result, I think they become very committed to the organization in a rather unique way. And I think this is perhaps even more important than the actual years of obligation that they incur through their education at USUHS.

Dr. ROWLAND. Well how does that compare with—the students coming out of the Armed Forces Medical School compare with the ability of the services to attract graduates from other medical schools? I mean what is the comparison there?

Dr. CASSIMATIS. The students who come in through the scholarship program, the HPSP program, I think, have also been of very high caliber in recent years. Unfortunately, the number of applicants has gone down somewhat in recent years and we are afraid it may go down further as part of the President's health care plan. A lot of scholarships are being offered for students in medical school who then pay back some of their obligation in the public sector. So although I think right now the argument is that the HPSP program could more than replace the students that come out of USUHS, that may prove to be a challenge, given a lot of other forces that I think will be operating in the overall medical arena in the future.

Dr. ROWLAND. How will these plans relative to the Armed Forces Medical School affect Eisenhower Medical Center as a teaching center?

Dr. CASSIMATIS. Well from the standpoint of having students enter the graduate medical education programs, that will not necessarily affect it, in that as long as we have students coming out of the HPSP program there will always be candidates for the graduate medical education programs at Eisenhower and in the consortium.

General LANOUE. Sir, the graduate medical education program is the centerpiece that retains the quality physicians and the nurses and the technicians and what-not that we have, because they know that first, as residents and trainees, they work in a high quality center that is on the cutting edge of technology. They also know that after they have worked up to the middle level of their career, they can return as faculty or associates of those programs and again work at the cutting edge of technology. And indeed, at the end of their career, they may be the professor. They have the op-

portunity to become the mentor, the senior person in that particular area, and have credibility in the civilian community at the professorial level.

Dr. ROWLAND. How is this going to affect our sharing agreement between the VA and the Medical College of Georgia here, the potential for the graduate medical education program not to function as well as we would like for it to?

General LANOUE. Sir, if you dry up the graduate medical education at Eisenhower Medical Center over a period of 6 to 8 years I think would become irrelevant. It would continue to provide primary care I think in the area and the advantage to the Medical College of Georgia is that they might get the referrals at the tertiary care level, but I think the whole character would be downgraded significantly.

Dr. ROWLAND. Do you have any additional questions?

Mr. JOHNSON. No, I do not think so.

Dr. ROWLAND. I want to thank all of you very much and I really do appreciate you being here this morning.

The third panel is made up of Mr. Walter Spivey, who is the local Commander of the Greater Augusta Chapter of the American Ex-Prisoners of War and Mr. Jack Steed, who is the President of the Air Force Association.

Let me say that the veterans' service organizations did not receive notice of this hearing in sufficient time to prepare testimony. We talked with them and they wanted to prepare testimony, but I think it took about 10 days or 2 weeks from the time we sent the notices out from Washington until they arrived here, so for that reason, we do not have as many VSOs here this morning as we would like to, but I do appreciate those who have come.

Mr. Spivey.

STATEMENTS OF WALTER SPIVEY, LOCAL COMMANDER OF THE GREATER AUGUSTA CHAPTER, AMERICAN EX-PRISONERS OF WAR and JACK STEED, PRESIDENT, AIR FORCE ASSOCIATION OF GEORGIA

STATEMENT OF WALTER SPIVEY

Mr. SPIVEY. Yes, sir, thank you. I am Walter Spivey, I have resided in Augusta since 1965. I was a prisoner of war in Korea during the Korean War, police action, conflict, whatever you identify that time with.

I have been treated by the Medical College—I beg your pardon, the Eisenhower Medical Center and later at the Department of Veterans Affairs. I have received excellent care from both of them. I would like to take this opportunity to thank them for their care and especially the VA and the Congress for their implementation of Public Law 97–37, which has improved the care for the ex-POWs considerably.

I have no prepared statement. I have even shorter time than you mentioned, sir, because my commander Rex Allen, who is the State commander, could not be here and I got very short notice. But I will try to answer anything you might want to ask me.

Thank you.

Dr. ROWLAND. Some things never change, do they?

Mr. SPIVEY. That is right.

Dr. ROWLAND. I want to thank my good friend, Jack Steed from Warner Robins for being here this morning. Thank you very much for coming over, Jack.

STATEMENT OF JACK H. STEED

Mr. STEED. Thank you, Congressman Rowland, it is a real privilege to be here, and I really appreciate you inviting me. I also want to thank you for holding these hearings outside the Washington area, on the scene. That has made it very convenient for all of us, thank you very much.

I would also like to say a word for your staff and Sam Nunn's and the other Georgia Congressional delegation staff members. You know, sometimes staff members are criticized in the press and so forth, but I had the opportunity to be in Washington the first part of the month, and we worked with them during the BRAC exercise and with this, and I want to tell you, they are bright, they are intelligent, they are dedicated, they are loyal and I am sure the service they give to you benefits us in the long run. So we want to thank you very much. I think it is remarkable how well the staffs work together and they say they even like each other. So I think that is great.

I would like to give you just a little background on me, maybe to give my testimony a little better perspective. I served in the U.S. Air Force for 33 years. For my grade, the normal time is 30 and we had the opportunity to apply and go before a board to be selected for a 3-year extended high year tenure, so I had 33 years, and I want you to know I enjoyed every minute of it. I love the Air Force, the other services, and if I was given the opportunity today, I would suit up today.

I would like to also point out, and this may give you a little better insight into my testimony, when I retired, I went to work for a bank, BankSouth, which is the largest Georgia-owned bank in Georgia. It has an excellent health program, but I did not elect it and the reason is my wife works for the Robins Air Force Base school system and she has the opportunity to take advantage of the Federal employee health benefit plan and it is better than the bank's, so that is the reason. I think later on, you will know why I mention that.

While we are not familiar with all aspects of the—before I get to that, Mr. Johnson, I am also Vice Chairman of the Robins Air Force Base 21st Century Partnership. You asked us for our support of the EAMC—well you have it. And this is a good learning process and we are learning how we can better support you and EAMC.

Mr. JOHNSON. Thank you.

Mr. STEED. We are not familiar with all aspects of the EAMC, but we do know of its importance and its great value to the Department of Defense and the excellent service it provides, not only to active duty members of the Air Force, but its retirees too. I am also pleased to learn of the sharing agreements between the EAMC, the VA and MCG. This is an excellent example of what we can do when we work together. I am also glad to hear about the proposed VA health plan, and Mr. Chairman, I am not being facetious, but we have got to see it to believe it.

Most retirees believe that they were promised lifetime military medical care by their commanders, their recruiters and retention personnel and the government in general. In fact, recruiting literature dated as recently as 1991 and being used now, states, and I quote: "Health care is provided you and your family members while you are in the Army and for the rest of your life if you serve a minimum of 20 years of active Federal service to earn your retirement."

Retirees are distressed that the Department of Defense has not adequately assumed this responsibility for the health care of their lifetime employees—military retirees. Retirees believe that they are entitled to lifetime military medical care by first earning it by 20 to 35 years of service and second for paying for it with mandatory Medicare deductions from their pay. At age 65, just when they need medical care the most, they are told based on arguments of DOD attorneys that their military benefit can be provided only on a space available basis and that they cannot even be treated at a military or veterans medical treatment facility and have medicare reimburse the facility for services rendered. Their bewilderment and frustration can be well understood.

The Armed Forces are being drawn too quickly and cut too deeply to support the DOD's simultaneous two-war scenario. This strategic plan cannot be adequately supported by the forces approved in the bottom-up review. Promises made by the government to recruit and retain men and women to provide the defense of the Nation, both in time of war and peace, appear to have been forgotten by many Members of Congress, the administration and the Department of Defense. It is clear that military retirees and families who have played a major role in the success of the All-Volunteer Force in the past are now becoming embittered as they find that the promises made to them years ago are not considered a legally enforceable contract and that the currently largely nonveteran White House and Congress have forgotten or simply do not understand about the promises made by previous administrations and congresses. If not corrected, these broken promises will result in the loss of retiree support for our volunteer force and we will eventually not be able to man the force with high quality, well educated personnel even at the lower levels.

Retirees are expressing a growing feeling of disaffection. Many are no longer willing to advise high quality potential recruits and retention prospects to consider a military career because they perceive that the Armed Forces, as an employer, has a clear history of breaking promises. The attitude of military retirees who helped build the volunteer force from the hollow force of the 1970s and 1980s, unless reversed, will eventually dismantle the high quality of the Armed Forces because high quality personnel at any significant levels will avoid military service.

The rationale that active duty beneficiaries have been significantly reduced by the drawdown of active duty personnel and therefore can reduce military medical personnel without loss of health care services does not meet the test of credibility and reality. This is true because the majority of military personnel released from the service due to the drawdown are young, healthy personnel requiring little medical care. On the other hand, the

older, married NCOs and officers with families remain and still are beneficiaries of the military health system, and those who have retired early and their family members continue to be eligible for care in military treatment facilities or under CHAMPUS. These planned military personnel reductions will greatly reduce the capability of medical personnel to care for these beneficiaries at the very same time medical facilities should be gearing up to take over the lead agent role of the military health plan as it implements its responsibilities under the President's health plan.

The prospect of a base closure, realignment and downsizing is one of the most difficult issues facing many communities today. The base is often an integral part of the community and has a very significant impact on the economy and employment. The base also provides many needed services to retirees and their families. Thus the closure or prospect of closure of a major base is traumatic, often throughout an entire region.

In his report to the Base Closure and Realignment Commission, then Secretary of Defense Les Aspin clearly defined the rationale for closing bases as a consequence of the declining defense budget and conformance with the 6-year defense plan. He further explained numerous assistance and transition plans available to active duty military members, civil service employees, private sector employees and local communities. Lacking in the Secretary's comments was any mention of the impact on the options available to the sizable military retiree community.

The most important benefit, and the one cited most by retirees, is continuing access to medical care. This access is promised by law and tradition and dates back more than 200 years. Prior to the 1950s the promise to provide military medical care was not questioned because throughout their military careers and in retirement, medical care was provided in military treatment facilities for personnel authorized to use these facilities. In 1956, there was 6.4 million beneficiaries and Congress made space available care in these facilities available to active duty dependents.

Today, however, there are 9.5 million beneficiaries. Retirees and their dependents comprise 50 percent of this group. As our armed forces are reduced and military installations and military treatment facilities are closed, space available care is becoming more scarce and this is why I was glad to hear about the VA health plan. I hope something happens there.

Loss of CHAMPUS benefits at age 65, just when they need it most, is a major concern among retirees. It is a great inequity that military retirees, their families and survivors are the only Federal Government employees who lose their entitlement to a medical benefit from their employer at age 65, upon becoming eligible for Medicare. We strongly believe that the Department of Defense should not be permitted to drop all legal responsibility for medical treatment of over age 65 military retirees. Legislation is urgently needed to recognize the explicit and implied promises and provide a defined lifetime benefit for retirees and their families and their survivors, regardless of age.

We fully realize the need to close facilities no longer in our Nation's best security interest. Many have closed and more will in the future. The Air Force Association believes that a host of health care

delivery programs for retirees, some existing, some developed but not funded and others being evaluated, should be studied in detail. The result of this careful study should determine which programs best meet the needs of retirees. To be successful, these programs must be affordable to the government and the retiree alike.

The Air Force Association applauds the 102nd Congress for recognizing the promise of lifetime medical care, the most crucial and necessary post-retirement benefit earned by military retirees. In a "Sense of Congress" resolution contained in Section 726 of the National Defense Reauthorization Act for fiscal year 1993, Public Law 102–84, Congress said in part, and I quote: "It is the sense of Congress that: Members and former members of the uniformed services and their dependents and survivors should have access to health care under the health care delivery system of the uniformed services, regardless of age or health care status of the person seeking health care . . ." And there is a lot of other considerations that it goes to, they are listed in my statement and in the interest of time, I will skip over them.

Dr. ROWLAND. They will be made part of the record.

Mr. STEED. Thank you.

The Federal employee health benefit plan, a program already in being, is highly regarded by analysts in and out of government. Just like I mentioned, I piggyback on my wife's. Military retirees are the only group of Federal retirees who currently do not have access to FEHBP. They are the only group of retirees who lose their major health benefit at 65, that program being CHAMPUS. Combining FEHBP with Medicare for those retirees over 65 would provide comprehensive care and would increase substantially the eligible pool, affording the government the opportunity of negotiating even more competitive commercial contracts. FEHBP also offers a key element of need to retirees—comprehensive coverage for prescription drugs. We recognize that many in the military medical treatment community have reservations about the applicability of FEHBP for military retirees. This program does, however, have outstanding features worthy of further review and consideration.

And in conclusion, Mr. Chairman, continuing to offer needed and earned benefits to retirees is a complex issue, especially where bases have closed or are closing. The Association applauds the Committee's interest in trying to find answers where there are no easy answers. We really appreciate your efforts in grappling with these tough issues. As you do, we hope you will remember that military personnel have been indoctrinated, trained, even ordered to be non-political. They are not a huge block of votes that have been politicized and are not politically organized. That is why they have always looked to Congress to champion the military. Congress has done this in the past because many "having been there" understood the military and the peculiarities of military life. But the number of those who "have been there" are dwindling and what has been taken for granted in the past cannot be counted on today. Congress has been our union and our protector. When that fades away, then the dedication, loyalty and patriotism as we know it today will also fade. The future of service to country, our future, is in the hands of Congress. May its hands always be strong and gentle for the members of the uniformed services and their fami-

lies. And please remember that your constituency in this regard extends far beyond the district you represent.

The foregoing testimony supports the essentialness of the Eisenhower Army Medical Center in providing necessary health care to active duty military personnel, retirees and their families in this State and elsewhere. Closure would cause a catastrophic impact upon these individuals, a great expenditure of time and money by these individuals and the government in order to reach more distant health centers. In fact, closure would exasperate the so-called health care crisis in America.

Thank you very much, Mr. Chairman.

[The prepared statement of Mr. Steed appears on p. 69.]

Dr. ROWLAND. Thank you for that very good statement. There may be some questions that we would like to ask.

Mr. Johnson.

Mr. JOHNSON. Thank you also, Mr. Steed, I appreciate that comment. And for the record, I want to note that the panel up here is not nonveteran Congressmen, both Congressman Rowland and I are veterans.

Mr. STEED. I know you are and we appreciate that very much.

Mr. JOHNSON. In fact, having served my time in the Air Force, I am glad to see another blue suiter in the room amongst all these Army folks.

Mr. STEED. I have on blue too.

Mr. JOHNSON. I am sure it is, you do not ever change their color.

I want to also comment on a couple of other things you said that are not necessarily related to the subject of this hearing, but I think are very important and need to be pointed out. I agree with you that there are some very strong concerns about our defense funding, particularly with the bottom review and the proposal to be able to fight two major regional conflicts at one time under the force structure that is being proposed. For those of you who are on the Veterans Affairs Advisory Committee, you know of my concerns in that area—I do not think it can be done under the current proposal, and there are many of us who feel that way on the Armed Services Committee.

Secondly, I also agree with you about the importance of installations in Georgia beyond the boundaries of our current districts. Being the only member on the House side on the Armed Services Committee, I consider all of Georgia my district for that purpose, and you may recall that last year when Warner Robins was put on the consideration list—I will not say the hit list—I made a tour of that base and participated throughout the hearings in trying to make sure that the objective analyses were made known to the BRAC Commission, that showed the importance of the continuation of that base. I think it is very important to our national security interests and I would put it up against any of the others that are being considered in that same category.

Mr. STEED. We appreciate that.

Mr. JOHNSON. Of course we feel the same way about most of the bases, in fact all the bases in Georgia, but certainly those that are in the 10th District.

Now let me just draw us back to the subject of this hearing and ask you just briefly, do you have any experience—you may not—

or does anybody in your Association have experience with these sharing agreements and the effect of those and how they play out for Air Force or other veterans?

Mr. STEED. None have come to my attention. Of course, I was pleasantly surprised, I was ignorant before I got here and I am just delighted to hear this is going on, this would be beneficial to everybody. Like I said, it is amazing what we can do when we work together, and I am just delighted to see that cooperation. I hope everybody picks up on it.

Mr. JOHNSON. I think you have pointed out some other questions I was going to ask about the priorities of military retirees, I think you stated that pretty clearly so I will not go over that again. I just want to thank you for your comments.

Mr. STEED. Medical being number one.

Mr. JOHNSON. Right.

Mr. Spivey, let me ask you, can you tell us what you think the role of the VA ought to be under any health care reform proposals?

Mr. SPIVEY. Could you repeat that?

Mr. JOHNSON. The role of the VA, can you tell us what—from your perspective what you think—how you think the VA ought to play out in health care reform.

Mr. SPIVEY. The health care reform that I have read about is so vast and so huge that I have not been able to comprehend all of it.

Mr. JOHNSON. Well let me just point out, there are a number of plans on the table—there is the single payer plan, there is the Clinton plan, there is the Cooper plan, there is the Rowland plan and there are some others. What we——

Dr. ROWLAND. The Rowland plan is the best. [Laughter.]

Mr. JOHNSON. I did not put that in order of priority.

Mr. SPIVEY. Well I think with the chairman we will be able to understand the language anyway.

Mr. JOHNSON. Right. What I was asking you though, regardless of what plan, assuming there is going to be some form of health care reform, would you have any suggestions with respect to veterans—VA hospitals and that sort of thing?

Mr. SPIVEY. Well I have probably been exposed and treated by some of this that you have heard this morning, because I do come to the VA here. And even when I was a patient at Fort Gordon, there were medical college students, who identified themselves as students or from the Medical College that came out there to practice. And here in the VA, I see people back and forth across that walkway all the time. It looks like a good program to me. I think as far as the veterans care, how you go about it, the most economical manner, to provide the best care, is to do what Mr. Lincoln said, to care for those who have borne the battle.

Mr. JOHNSON. And are you satisfied that that is being done now under the current situation?

Mr. SPIVEY. I do not know of any situation, sir, that cannot be improved, there are some in all areas. And as veterans' organizations, we try to inform the people who are responsible for that and assist in any way we can in having that done. The biggest problem right now with the VA is the rating, the claims, and it is a disaster. A claim takes forever. You could write a postcard to Atlanta—I

have absolutely no complaint with the treatment that I have been receiving here at the VA Medical Center, as I told you, since that law was passed back in the 1980s, it has improved considerably. And under our present director, he is very firm about that program and we are receiving, I think, very good care. But now Atlanta, you could write the VA in Atlanta a postcard and ask them what time it is, and it will be 6 months before they get around to coming back with an answer. [Laughter.]

Mr. JOHNSON. Well one of the proposals is that VA stay like it is, but be sort of a—part of the market from which veterans can draw from, you can go under one plan or you can go under the veterans plan. Is that the way you would like to see it?

Mr. SPIVEY. Yes, sir, I would like to see that, I would like to have the option. I do not want to be a prisoner any more any place, and I now have—I am retired military which authorizes me certain care, as the budget will allow, and I am qualified for anything at the VA, which I receive. I have kept my government employee insurance, my wife can use CHAMPUS and I still want the option or would like the option of going where I am satisfied with the treatment. Right now I am satisfied, but that does not mean when this new program comes in that I am going to be satisfied at that particular point. And I do enjoy the option—would enjoy having that option of going someplace else if I so desired, and I anticipate if that comes about and there is a voucher system, there will be a great exodus from the VA and they will slowly return when a lot of people find out that, regardless of which doctor you go to, Mr. Chairman, you have got to wait. You cannot serve everybody all at the same time. So I would anticipate that happening.

Mr. JOHNSON. Right.

And going particularly to the subject of this hearing, have you seen the operation of these sharing agreements? Have you had any discussions with other veterans about that, about the way the veterans center, the VA center, and the Medical College and Eisenhower are working together on a number of different——

Mr. SPIVEY. Yes, sir, I have talked to some, and one of the first things that comes up is very common, why does the VA pay the Medical College to train their doctors. That is one question that somebody asked me to ask this panel or ask you—why should the VA pay the Medical College for that. We have discussed some, and most people that I talk to, there is a lot of us, I cannot give you a percentage, that realize that we have a very good hospital here and we are very proud of it and we are proud of the people that run it, and our treatment there. And I do not anticipate leaving. I do not see any point in getting off a good horse to try out another one. But some people are unhappy with it, but there again, it is impossible to keep everybody happy, especially if you come looking for something to gripe about. And unfortunately we have some people like that, but my fellow serviceman here, retiree, I did not need to prepare a statement, he said everything, he said it very well too, and I second it.

Mr. JOHNSON. Okay, thank you very much, Mr. Spivey, and I will refer your question to Tom Ayres, although I think part of his testimony should have answered that, the cost efficiencies of combining

the physicians in the Medical College with VA, I think should play that out.

Mr. SPIVEY. Sir, anything, as I said earlier, that will reduce the cost and provide better service, I do not care what you call it—joint, you can put any kind of initials you would like to on it—that is what we are all interested in, I think.

Mr. JOHNSON. Right. Well that is the answer to your question, I think.

Mr. SPIVEY. Yes, sir, because we are very, very tired of hearing at the dental clinic at Fort Gordon, we cannot make an appointment for you, if you have an emergency we will snatch your tooth out or give you something temporarily and you can go to your dentist tomorrow—why, as he asked—because we do not have any money. And you go someplace else and it is the same thing. We all have problems with money, but I agree with him, three wars and promises should be kept to people from that era. When we get older, as I am now—I did not ask for anything when I was young except more ammunition. [Laughter.]

Mr. SPIVEY. And in Korea, I got 25 rounds of artillery shells per day because we did not have enough ammunition because we did not have enough money. I am tired of that. I mean, we are spending a lot of money other places, let us put some here.

Thank you.

Mr. JOHNSON. Thank you.

Dr. ROWLAND. I have one question that I want to ask. We were talking about military retirees. I believe you were indicating that they should not be brought under Medicare at age 65 but rather continue the kind of care that they had been getting prior to 65, is that right?

Mr. STEED. Yes, sir, that is what I meant to say.

Dr. ROWLAND. Okay, well I think that is what you said. I just wanted to restate it.

We are really interested in knowing from the veterans here in this area what they think about this sharing. That is the principal focus of the hearing. You have answered——

Mr. STEED. It was worth my trip up here just to learn, I wish we had already known it and I could have maybe made other comments, but I think it is great.

Dr. ROWLAND. You have addressed that some, Mr. Spivey.

Mr. SPIVEY. Well I will have to plead some ignorance, I do not think there has been a lot of publicity on this, a lot of people do not know about it.

Dr. ROWLAND. It is not well known.

Mr. STEED. I am going to communicate it to our 6,000 members as soon as I get back.

Dr. ROWLAND. I would like to invite any—if there are any veterans in the audience here that would like to comment on the focus of this hearing, I would be pleased to hear from them.

Mr. SNAPPERMAN. Mr. Snapperman here, I am on the Board of Retirees at Fort Gordon.

On the Medicare, I do not see why we cannot stay in the VA and DOD system, being that they can use our money from Medicare when we do hit 65.

Dr. ROWLAND. That is the point you were making, Jack, as well.

Mr. STEED. Right.

Mr. SNAPPERMAN. Where we do not have to separate anywhere else, just stay in the system.

Mr. STEED. People look at it, Mr. Chairman, as a blatant case of—a perception of a blatant case of age discrimination.

Dr. ROWLAND. I see, and that is a general feeling among military retirees, that they ought to be able to continue to get the same kind of benefits they had before age 65, and not have to receive the care under Medicare.

Mr. SNAPPERMAN. Right. We seem to be being squeezed out of the system. And we put in our time and we were promised this here through the recruiter and we expect it. And I hear other areas are being affected that will squeeze out the retiree too.

Dr. ROWLAND. CHAMPUS beneficiaries are placed under Medicare as well at age 65.

Mr. SNAPPERMAN. Right. I think you lose CHAMPUS when you hit 65.

Dr. ROWLAND. That is right.

Mr. SNAPPERMAN. But Medicare should kick in at that point. And the military, DOD hospitals, should be still compensated so they are not losing anything.

Dr. ROWLAND. Well I appreciate that.

Any other veterans here who would like to make a comment about what we are focusing on here?

Yes, sir, if you will—do you want to come up, or maybe you can talk loud enough from back there.

Mr. CRAWFORD. Thank you, Mr. Chairman.

As a veteran who has been served at several VA facilities, I would like to really praise the Augusta facility here and the sharing agreement with MCG. I have been on the operating table several times, I have been through MCG for services across the hallway there. It is definitely very important to continue that sharing agreement and be used as a model across the United States. As I said, I have been treated at other VA facilities that were not fortunate to be co-located with another facility and have a close working agreement.

Dr. ROWLAND. Would you identify yourself please?

Mr. CRAWFORD. Yes, sir, I am Ian Crawford with Carolina Veterans' Association.

Dr. ROWLAND. Thank you, we really appreciate that.

Mr. CRAWFORD. Thank you.

Dr. ROWLAND. Anyone else?

Mr. STEED. I think most people would feel that way, sir, if they knew what was happening.

Dr. ROWLAND. Well you are saying this just is not known well enough then about what is going on.

Mr. STEED. That is right.

Dr. ROWLAND. Well I hope this hearing will help focus some attention on that.

General.

General SPAULDING. I would just like to re-emphasize the fact about how important that Medicare reimbursement to DOD for services rendered. Certainly from my standpoint as a hospital commander, that gives me more flexibility to provide resources for folks

when they get over 65 and lose their CHAMPUS eligibility, so that is really, really key, is that Medicare reimburse DOD for medical services rendered.

Dr. ROWLAND. The money that you get from Medicare is important.

I guess the point that they are making is that they would like to continue to get the kind of benefits that they have had before that. How would that work? How could we address that?

General SPAULDING. Well I think that is going to take some type of law change, I would assume. I mean it is a statutory limit, once you get over 65, you lose your CHAMPUS benefits, and you become Medicare eligible. That is law, so I think some type of law would have to be changed at your level to make that happen.

Mr. JOHNSON. As I understand it—I am not an expert on this, but as I understand it, that applies to all people. You know, if you have private health insurance, it generally cuts off at 65 and you go on Medicare.

Dr. ROWLAND. If you are retired.

Mr. JOHNSON. If you are retired. And so what it would have to be is to make an exception for military retirees.

Dr. ROWLAND. Someone back there had raised their hand.

Colonel REICH. Yes, sir, I am Colonel-retired Robert Reich, I am a member of the local Association of the U.S. Army. I am also a member of the Governor's Council on Military Coordinating Committee and I am also the former Chief of Staff of Fort Gordon, and I am very familiar with the graduate medical training program that Fort Gordon is involved in. I am also an employee of the Chamber of Commerce.

Of course from many angles, I see the great importance of the synergism of the Eisenhower Army Medical Center, the VA Medical Center and the Medical College of Georgia, not only the great care that it gives us and the great savings that we incur because of the care they are able to offer, but the great economic development engine that they are for this entire region, not only for Augusta and the surrounding counties, but it extends well into all of Georgia and South Carolina.

So the importance of this partnership just cannot be understated. I know the local association, AUSA, strongly supports the continued health of the VA Medical Center and the Eisenhower Army Medical Center.

Thank you.

Dr. ROWLAND. Thank you very much.

Well I want to thank all of you for coming. I think this has been a really good morning, at least from my standpoint, and Congressman Johnson as well, and I hope it will be beneficial, and maybe we can get the word out of how well this does seem to be working.

Mr. STEED. Do you have something in writing that describes this? I would be happy to send it to all our members.

Dr. ROWLAND. I think we can get that to you.

Mr. SPIVEY. I would like to question or maybe request something. I have private insurance, as I said, and that Medicare. With all these others, I still pay this one, but my private insurance, I have brought that to the VA and I understand now the Army is doing the same thing, for payment of certain treatments that I get. My

insurance company only sends me a form of the date I went to a clinic and the amount and they did or did not—well I have not gotten one where they paid anything yet. I would like to have—for the veterans that have that and use it, to have a little more information on what the VA did for me and what they sent in to the insurance company and what is being paid. I do not know if I am getting anything for my money—or the VA is getting anything for my money I am paying for that private insurance or not.

Thank you, sir.

Dr. ROWLAND. I thank all of you very much for coming. We stand adjourned.

[Whereupon, at 11:31 a.m., the subcommittee was adjourned.]

APPENDIX

HEARING OF SUBCOMMITTEE ON HOSPITALS & HEALTH CARE FOR THE COMMITTEE ON VETERANS' AFFAIRS

STATEMENT OF
CHARLES H. WRAY, M.D.
VICE PRESIDENT FOR CLINICAL ACTIVITIES
MEDICAL COLLEGE OF GEORGIA

Dr. Rowland, if you will permit me a personal statement, I want to welcome you in your role as Congressman and especially state the pride that we have in your accomplishments, both in your service to your community as a physician and as a graduate of the Medical College of Georgia. We appreciate the advice that you gave to our graduates in recent years at the Hooding Ceremony.

Though it may be known to you, I would like to speak of the historical relationships between the Medical College, the Veterans' Administration Hospital and the Dwight David Eisenhower Army Medical Center in Augusta, Georgia.

During the second world war, the old Forest Hills Ricker Hotel was converted into a military hospital and following the second world war, that facility was converted a Veterans' Administration Hospital. I spent part of my student rotations and resident rotations in that old facility. Because of a unique relationship that had been in place between that hospital and the Medical College, when the new Veterans' Administration Hospital was constructed, a site next door to the Medical College was selected and a physical connection across Harper Street was made to facilitate the movement of patients, physicians and students so that our integrated and mutually dependent programs would be facilitated.

Likewise, Fort Gordon has developed since the second world war with early provision of consultative services between the Medical College and the Fort Gordon Hospital. When the Dwight David Eisenhower Medical Center was constructed there began to be a closer relationship between the Medical College and that facility. Over time we have shared not only consultative services but have shared patient care services. The professional personnel at the Eisenhower Hospital have been well trained and fully capable to participate in our educational programs, even at the most advanced level.

We in academia are fond of speaking of the three legged stool of teaching, research and patient service and consider those activities interdependent. I believe that the Dwight David Eisenhower Medical Center, the Veterans' Administration Hospitals and the Medical College likewise represent a mutually dependent three legged stool. There is thus a need to preserve these consortial relationships for the advantage of all our citizens.

I would like to speak of some of the programs that I believe are important economically. The Georgia Radiation Therapy Center was developed at the Medical College as a shared community resource. Patients from the community hospitals as well as the Medical College, Eisenhower and the Veterans Administration are treated there. This facility has allowed us to avoid duplication of expensive equipment and personnel. Two of the community hospitals

have subsequently chosen to develop their own radiation therapy programs but the linkage between our three institutions has remained firm.

Many years ago when the Medical College was in the process of renovating its Radiology Department, a vascular special procedures facility was developed in which the space and technical personnel was provided by the Veterans' Administration while the equipment was provided by the Medical College. I believe that not only has this saved money, but I would challenge you to find a Veterans' Administration Hospital in the Country that can provide angiography procedures seven days a week as promptly as this facility does. There are examples of sharing between the Eisenhower facility and the V.A. facility. Currently, the Neurosurgery Surgical Services at the Veterans' Administration provides acute care for both active duty personnel from Eisenhower and veterans at the V.A. facility. This was a consolidation that has developed in the last year.

I should relate that the Medical College faculty, in many instances, is shared with the Veterans' Administration. The Regents of the University System have allowed tenure to be awarded to these physicians. Many of our departments have faculty that are full time or part time at the V.A. depending on needs. There obviously are some departments such as Pediatrics and Obstetrics & Gynecology that do not have services within the Veterans' Administration because of the predominance of adult males as patients.

Our under graduate and post graduate medical education programs are fully integrated with the Veterans' Administration. Nearly all of the departments have residents on regular rotations at that facility. As you know, we usually place medical students in programs where there is a full range of educational experiences available.

Another example of cooperative efforts between the Medical College and the VAMC is a plan that is being developed to bring the two medicine services together. An easily understood example of what is involved here would be, for instance, the further integration of our cardiology services to the point that we might only operate one cardiac catheterization unit. This sharing of resources and personnel clearly is a benefit.

Historically, at the Eisenhower Medical Center, the residency programs have provided most of their experiences there and we have had some rotations between the Medical College and Eisenhower in departments such as Anesthesia, Dermatology, Obstetrics & Gynecology and Surgery.

Clinical and basic research has likewise been a shared responsibility. During the construction of the acute care hospital, considerable space was devoted to research since the Veterans' Administration has supported such activities particularly with medical school faculty's and ours has not been an exception. Recently, when our institute of Molecular Biology and Genetics was established, there was a need for temporary space while renovations were being done. The V.A. gladly participated in this and as a result more permanent research activities are now ongoing there. There are now seventeen protocols that are being developed particularly surrounding breast carcinoma and women's issues that will be shared with Eisenhower.

I would like to address the development of future interactions. The Medical College currently has a Children's Medical Center within the confines of its acute care hospital and currently the architects are working on the final plans for a new structure to house the Children's Medical Center. While we have specialists in these areas, this Spring two military physicians, one a pediatric orthopedist and the other a pediatric radiologist will be stationed at Eisenhower and will participate in our programs at the Medical College. We believe it also logical that the bulk of the children's care should be carried out through joint cooperation with Eisenhower to provide for active duty military personnel who are stationed there. The child psychiatry program has a long and rich history of cooperation. When our Psychiatry Department was without a chairman recently, Eisenhower provided a section leader for that Child Psychiatry. This allowed the continued function of that valuable service.

With the down sizing of military personnel including physicians, we entered into discussions to fully amalgamate and integrate the residency programs. By July 1994, the General Surgery residents at Eisenhower and the Medical College and V.A. should be fully integrated under one program. Plans are under way in Orthopedics to do the same by July 1995. Currently, there is a resident from Eisenhower who participates in our Emergency Medicine residency and in time we hope that this program will be fully integrated as well.

One exciting area of collaboration is with Telemedicine. As is true in rural Georgia, the military has many remote stations. The Telemedicine program at the Medical College has received national notice and is considered the most advanced application of this technology. Along with NASA and the Department of Defense, there have been discussions about the best uses of this technology. One can easily visualize a remote site with limited professional personnel who need consultative advice. This technology which makes one feel almost like one is in the presence of the patient will be valuable in such circumstances to the DOD.

We would ask your assistance then that we be allowed to continue our present interactions. We believe these are programmed to be mutually beneficial, hopefully less expensive through sharing.

There are two areas in which the committee could be of great assistance. Each of our three institutions is enmeshed in a bureaucracy. We would ask for some relaxation of rules to allow us to interact more freely.

One particular issue that is a present barrier relates to medical liability. There is some disagreement as to the interpretation of the Gonzalez amendment as relates to the ability of an active duty physician to treat a non-federal beneficiary. We believe that if our program could be construed so as to allow the commander to state that such activities are a part of the regular duties, that one barrier would be removed. We will continue to explore this and other methods to protect our physicians and patients from needless legal entanglements.

I appreciate this opportunity to present this information to you and if we at the Medical College can be of further assistance, please ask.

Statement of

VERNON C. SPAULDING, COMMANDING GENERAL
DWIGHT DAVID EISENHOWER ARMY MEDICAL CENTER
FORT GORDON, GEORGIA

Before the Subcommittee on Hospitals and Health Care
Committee on Veterans Affairs
U.S. House of Representatives

Augusta, Georgia - February 18, 1994

Mr. Rowland and Mr. Johnson, I sincerely appreciate this opportunity to participate in this hearing and your interest in the exceptional partnership that has developed between the Veterans Affairs Medical Center, the Medical College of Georgia, and Eisenhower. The potential benefits of this relationship are clear and compelling. This morning I would like to describe for you the mission of Eisenhower Army Medical Center, how we have begun to refocus our efforts in the context of health care reform, and to discuss some of the many benefits of our joint efforts to improve access to services and reduce costs. I am joined by my colleague, Colonel Sidney R. Steinberg, who serves as the Chief, Department of Surgery and the Director of Medical Education.

Dwight David Eisenhower Army Medical Center is located at Fort Gordon, Georgia and was dedicated in 1975 in honor of General Eisenhower, the 34th President of the United States. Eisenhower is fully accredited by the Joint Commission on Accreditation of Healthcare Organizations and is an institutional member of the American Hospital Association, the Georgia Hospital Association, and the Augusta Area Hospital Council. The institution comprises some 35 separate outpatient clinics, educational, and research facilities. Eisenhower also operates Army Health Clinics at Fort McPherson, Georgia and Fort Buchanan, Puerto Rico. Inpatient services include 371 operating beds and 26 special care beds for medical, surgical, and coronary intensive care. There are eight operating rooms. Ambulatory surgery services comprise nearly one-half of all surgical procedures accomplished at Eisenhower. The health sciences library offers 15,000 volumes, over 500 medical journals, and a

sophisticated nationwide scientific database network. We have also been deeply involved in testing and refining a hospital-based fully integrated management information system for the Department of Defense, the Composite Health Care System. Eisenhower employs 1,600 military and civilian staff and has an annual budget of $148 million. Salaries and supply purchases provide $70 million
to the local Central Savannah River Area economies.

Eisenhower provides primary care to nearly 60,000 active and retired military members and their families, who live within 40 miles of Fort Gordon. As the largest tertiary care military referral center in the Southeast, we also provide highly specialized referral care to some 1.3 million beneficiaries in seven states and Puerto Rico. The region's medical facilities support the Army, Navy, and Air Force highest priority fighting forces at Fort Bragg, North Carolina; Fort Benning, Georgia; Fort Stewart, Georgia; Fort Campbell, Kentucky; Jacksonville, Florida Naval Facilities; Kings Bay Submarine Base, and others. Additionally, included in our region are the Commander-in-Chief, Central Command, the US Army Forces Command, and the 9th US Air Force. Clearly, Eisenhower provides important medical support to our nation's most visible defense forces.

We provide fully accredited graduate medical education programs in family medicine, internal medicine, general surgery, orthopedic surgery, child and adolescent psychiatry and pathology. Approximately, 110 physicians are in various post graduate medical education programs at all times, and each year we provide nearly 45 fully trained specialists for assignments throughout the Army.

Recently, the Department of Defense announced a significant effort to develop accountable military health plans focused on local military hospital catchment areas led by designated tertiary care centers in twelve regions of the United States. Eisenhower was designated as the Lead Agent for DoD Region III which encompasses Georgia, South Carolina, and most of Florida. The Regional mission is in addition to the Army assigned

responsibilities for command of seven Army Community Hospitals in Alabama, Kentucky, Georgia and South Carolina. The concept of a regional managed care agent gives Eisenhower the opportunity to define and manage a health plan for the three states in a partnership with a managed care contractor. This program acknowledges the leadership role of regional medical centers to identify the highest quality, most cost-effective health care available. The development of a military health care plan is critical to ensure that the military health service system optimizes its use of direct care resources necessary to sustain readiness as well as effectively organizing and managing the civilian resources needed to provide the full range of services mandated by the benefits structure of the Civilian Health and Medical Program of the US, or CHAMPUS. In addition to the fee for service indemnity product offered by CHAMPUS, we will in partnership with a managed care contractor offer more cost-effective options such as health maintenance organizations and preferred provider organizations.

Our partnership with the VA and MCG and the medical resources found in Augusta will most certainly enhance and facilitate our development as the provider of highly specialized and extensive medical services to the approximately 1.3 million potential beneficiaries in our region. Our VA/DoD relationship is based upon our mutual commitment to a joint venture process to improve service availability and contain costs. This concept supports the goals of Public Law 102-585 of November 4, 1992, and offers a clear example of enhanced governmental efficiency, cost avoidance, and improved access to services through joint venturing. To date we have agreements in neurosurgery, women's health services, Medical Resonance Imaging, reference laboratory support, and rheumatology. We have other prospective opportunities to share staff, services, equipment and facilities to enhance the efficiency and effectiveness of both agencies.

The Medical College of Georgia has been a long-term partner of both the VA and Eisenhower. We have traditionally supported each other in the training of physicians and other health care

professionals. Recently, we have commenced a detailed process to explore the benefits of affiliating our graduate medical education programs where it makes good sense to do so. Additionally, we have also started discussions concerning our mutual interest in the emerging technology of telemedicine. The strategic commitment of MCG to this technology and its potential applications in remote situations that could exist in the context of national defense as well as our consultation specialty service in the Southeast suggest that a partnership in this area could benefit the Department of Defense. As you know, Fort Gordon is the Army's Signal Center which offers additional synergy to the development of telemedicine applications.

In summary, Eisenhower Army Medical Center is a value-driven, customer-focused institution moving forward in developing programs and services to meet our nation's medical readiness goals and the expectations of our patients. We have assumed a leadership role in the Southeast for medical readiness and the DoD response to health care reform. We are actively seeking to acquire new technologies such as telemedicine to facilitate achievement of our goals. Our graduate medical education program represents for us our strength and gives us the ability to extend specialty medical services to our region. Our partnership with the VA and the Medical College adds great depth to our capabilities, and more importantly, gets at the very heart of health care reform through cooperation across a wide spectrum of issues that offer the potential for improved access and cost containment. We are tremendously proud of this partnership and seek to formalize it through approval of a demonstration project process to the Department of Defense. Again, thank you for your attention this morning. Dr. Steinberg and I would be pleased to answer any questions you may have.

REMARKS BEFORE THE CONGRESSIONAL
SUBCOMMITTEE
FEBRUARY 18,1994
AUGUSTA, GEORGIA

SIDNEY R. STEINBERG,COL MEDICAL CORPS
DIRECTOR, MEDICAL EDUCATION
CHIEF, DEPARTMENT OF SURGERY
EISENHOWER ARMY MEDICAL CENTER

CONGRESSMAN ROWLAND, CONGRESSMAN JOHNSON AND DISTINGUISHED MEMBERS OF THE COMMITTEE STAFF; I WOULD LIKE TO THANK YOU FOR THIS OPPORTUNITY TO ADDRESS THESE MATTERS OF GREAT IMPORTANCE TO OUR COMMUNITY AND OUR NATION .

SEVERAL YEARS AGO, WHEN HE COMMANDED THE UNITED STATES ARMY HEALTH SERVICES COMMAND, OUR CURRENT SURGEON GENERAL, LTG LANOU, CHALLENGED THE ARMY HEALTH CARE DELIVERY SYSTEM TO ASSUME A NEW POSTURE. HE DEMANDED THAT WE IMPROVE THE QUALITY OF CARE WE PROVIDED OUR PATIENTS , DEVELOP A SYSTEM OF BETTER ACCESS TO THAT CARE AND THAT WE REDUCE HEALTH CARE EXPENDITURES TO COMPLY WITH FEDERAL BUDGETARY CONSTRAINTS. GATEWAY TO CARE WAS BORN . A MODEL SYSTEM OF HEALTH CARE SERVICES EVOLVED AND THE ARCHITECTURAL DREAM OF THE ARMY'S GATEWAY PROGRAM BECAME A RESOUNDING SUCCESS.

IN AUGUSTA, GEORGIA THAT MODEL WAS FORGED UTILIZING EVERY AVAILABLE RESOURCE, INTEGRATING NEW IDEAS WITH OLD PATTERNS OF PRACTICE AND DEVELOPING BROAD-BASED, PATIENT - ORIENTED PROGRAMS THAT MADE GOOD ECONOMIC SENSE. THE DOORS OF EISENHOWER ARMY MEDICAL CENTER, THE AUGUSTA VETERANS ADMINISTRATION MEDICAL CENTER, AND THE MEDICAL COLLEGE OF GEORGIA OPENED TO EACH OTHER IN A NEW MORE MEANINGFUL WAY. WE BEGAN TO LEARN FROM EACH OTHER, AND TO FORGE FROM THAT LEARNING EXPERIENCE, A PROCESS OF

RESOURCE UTILIZATION THAT HAS BECOME OUR BLUEPRINT FOR THE CONSTRUCTION OF AN EFFECTIVE MANAGED HEALTH CARE PROGRAM FOR THE SOUTHEASTERN UNITED STATES.

FUNDAMENTAL TO THAT PROGRAM IS ONE OF OUR NATION'S FINEST MEDICAL EDUCATION SYSTEMS. A SYSTEM EMPLOYING GREAT ACADEMIC LEADERS, EXPERIENCED ADMINISTRATORS, AND SUPERIOR TECHNOLOGIC ADVANCES THAT WILL SOON BRING THE WORLD'S PATIENTS TO OUR OPERATING CONSOLES IN AUGUSTA.

WE ARE A TEAM; EISENHOWER AND FORT GORDON, THE VA MEDICAL CENTER, THE MEDICAL COLLEGE OF GEORGIA. TOGETHER WE PROVIDE THIS COMMUNITY, THE SOUTHEAST REGION, AND THE NATION WITH A POWERFUL HEALTH NETWORK TO SUPPORT THE NEEDS OF OUR BENEFICIARIES AND PATIENTS. WE ARE ON THE RIGHT COURSE TO MEET THE NEW HEALTH CARE AGENDA. WE ARE YOUR SUCCESS STORY, SHARING RESOURCES, AVOIDING WASTE AND DUPLICATION, IMPROVING PRODUCTIVITY, ADDRESSING DEFENSE REQUIREMENTS AND BUILDING ON A SOLID FOUNDATION OF QUALITY MEDICAL EDUCATION THAT WILL MEET FUTURE CONTINGENCIES BE THEY CIVILIAN OR MILITARY.

THE PATH WE HAVE TAKEN IS UNCHARTED, BUT IT IS CLEARLY THE RIGHT PATH. IT MEETS ALL OF THE REQUIREMENTS IN A PROFESSIONALLY AND FISCALLY SOUND WAY; PREPARING MEDICS TO GO TO WAR , SUPPORTING WORLD-WIDE DEPLOYMENT MISSIONS, PROVIDING NEUROSURGICAL CARE TO OUR VETERANS, ADDRESSING WOMEN'S HEALTH NEEDS , AND PROVIDING FOR THE CRITICAL CARE OF THE SOLDIER'S NEW BORN CHILD, TO NAME BUT A FEW. WE WORK HARD TO REDUCE SUPPLY COSTS THROUGH JOINT PURCHASING AGREEMENTS, WE SHARE EACH OTHER'S DOCTORS AND NURSES AND WE MAKE OUR BEDS AND OPERATING ROOMS AVAILABLE ON A SHARED BASIS TO REDUCE ADDITIONAL CAPITAL EXPENDITURE REQUIREMENTS. WE ARE DOING NOW WHAT SHOULD HAVE BEEN DONE MANY YEARS AGO.

THE LEADERSHIP OF THE MEDICAL COLLEGE OF GEORGIA, THE VETERANS ADMINISTRATION MEDICAL CENTER AND EISENHOWER ARMY MEDICAL CENTER HAVE TAKEN A GIANT STEP IN

THE HEALTH CARE REFORM ARENA. THEY NEED OUR SUPPORT. THEY NEED YOUR SUPPORT. HELP US TO REMOVE THOSE SMALL OBSTACLES THAT ENDANGER THE CONTINUED SUCCESS OF THEIR EFFORTS. LEND THESE COURAGEOUS LEADERS A HELPING HAND. DEFEND THEIR EFFORTS TO RETAIN OUR MILITARY EDUCATIONAL PROGRAMS, FOR IT IS FROM THEM THAT WE GAIN OUR STRENGTH AND IT IS THROUGH THEM THAT WE SHARE THIS COMMON BOND.

OUR PLEDGE TO YOU FOR THIS SUPPORT, LADIES AND GENTLEMEN, IS THAT WHEN YOU NEED US WE'LL BE THERE, FOR AUGUSTA, FOR GEORGIA AND FOR OUR COUNTRY. THANK YOU.

Statement of

THOMAS L. AYRES
MEDICAL CENTER DIRECTOR
VETERANS AFFAIRS MEDICAL CENTER
AUGUSTA, GEORGIA

Before the Subcommittee on Hospitals and Health Care
Committee on Veterans' Affairs
U.S. House of Representatives

Augusta, Georgia - February 18, 1994

The VAMC in Augusta is a two-division, 1033-bed, highly complex, VA/DoD Joint Operating Medical Center. The Downtown Division is a 380-bed acute medical and surgical facility including a 60-bed Spinal Cord Injury Unit. The Uptown Division is a 653-bed psychiatric and intermediate medicine facility and includes a 60-bed Nursing Home Care Unit. The VAMC in Augusta currently employs 2,300 staff members with an annual budget of approximately $130 million. I was appointed Director at Augusta in June 1990. Since my appointment, I have worked diligently to renew and enhance VA/DoD relationships. During the past 18 months, I and members of my staff have worked with the Commander and staff of the Dwight David Eisenhower Army Medical Center (EAMC) to create a VA/DoD Joint Venture for Shared Services (JVSS). This innovative operational concept is dedicated to enhancing opportunities for cost effective sharing of medical resources between co-located federal health care institutions. The intent of the agreement is to consolidate services, where practical and cost effective, to avoid duplication, to achieve economies of scale and to take greater advantage of those situations in which one of the two institutions has ample services for which the other institution has a defined need.

The agreement represents a coordinated effort to consolidate, where practicable, the alignment of services and the contributions of the two institutions so that the consolidation results in an equal input of resources by each institution. Under this operational scenario, little or no actual money would change hands. We believe that these initiatives have great potential for real enhancement of the services which we provide to both our beneficiary populations. We further believe that this agreement has the potential to establish a viable example of federal cooperation in providing "state of the art" health care, education and research opportunities for co-located VA and DoD medical care facilities nationwide.

Since initial approval of the JVSS "Concept of Operations", we have identified Joint Venture Coordinators at both facilities, initiated JVSS management through an Executive Management Team, consolidated EAMC's Neurosurgery program with the VA Medical Center's neurosurgery section at the VA Medical Center and shared invasive cardiology support during May 1993.

We have also shared medical transcriptionist services after EAMC lost a significant number of staff, and shared one of EAMC's rheumatologists who routinely staffs the VAMC's outpatient rheumatology clinic.

Based upon our continuing "needs/excesses assessment" process, the Executive Management Team is considering additional short term planning initiatives involving Orthopedic Surgery, Internal Medicine sub-specialties, Gynecology, Radiology (Medical Digital Imaging Systems), Sleep Laboratory Services, Substance Abuse, Physical Medicine and Rehabilitation, Joint Procurement and Champus Business Initiatives. Longer term initiatives potentially involve joint procurement of radiation therapy equipment, a joint venture to construct, equip and operate a free standing Ambulatory Care and Day Surgery Center, establishment of a rural health care program utilizing outreach clinics, and integration and consolidations, where practical, of other VA/EAMC programs and services.

For many years, the Medical College of Georgia (MCG) and the Veterans Affairs Medical Center in Augusta, Georgia, have enjoyed a mutually beneficial affiliation relationship. As a Dean's Committee Hospital, the VA Medical Center has provided an essential clinical training milieu in a broad spectrum of clinical specialties and sub-specialties. The VA Medical Center has also provided opportunities for collegial association and training in specialty areas such as acute and long term psychiatry, substance abuse, physical medicine and rehabilitation, post traumatic stress disorders and treatment and rehabilitation of patients with spinal cord injuries. The VA Medical Center annually funds 84 resident slots at a cost in excess of $2.8 million and, in addition to the academic benefits of supporting the respective residency programs, the VA Medical Center derives specific patient care treatment and support benefits from the affiliation with the Medical College of Georgia.

The VA Medical Center has come under intense scrutiny by the Office of the Inspector General with regard to all sharing and contracting activities. The increased regulatory and procedural demands that have been placed upon the VA Medical Center's authority to contract for "scarce medical specialists" services have resulted in some abrupt, though essential, changes in contracting and sharing relationships between our two health care organizations. These changes have been uncomfortable for both parties but decisive management actions have resulted in development of better cost and pricing procedures. At the present time, the VA Medical Center purchases the following services from the Medical College of Georgia: General Medical Services, Radiology Services, Neurology Services and Radiation Therapy Procedures via sharing agreements and Anesthesiology Services, Open Heart Surgical Services, Nuclear Medicine Services, Radiologist Services and Radiological Physics via Scarce Medical Specialists Contracts.

We are currently considering the potential for consolidating diagnostic and interventional cardiology services for both institutions at the Medical College of Georgia. In all cases, sharing agreement and scarce medical specialist services contracting authorities are used to procure services not available at the VA Medical Center, those which can be provided more cost effectively outside the VA or as mutual use back up agreements.

I believe that by sharing resources with other federal health care providers, with our affiliates and private sector providers the Department of Veterans Affairs will continue to improve its ability to provide high quality care to the greatest number of eligible veterans. Operating with an annual budget is a fact of life in the provision of health care, whether that care is provided in the private sector or in federal facilities. With the advent of dramatic changes in the national approach to the development, financing and organization of managed health care systems capable of providing accessible health care for all Americans, we realize the need for flexibility, acknowledge the inevitability of change and, most importantly, reaffirm the value of continuing and enhancing the strengths of cost effective sharing of quality scarce and specialized medical resources.

I would be pleased to answer any questions you may have.

JOINT VENTURE FOR SHARED SERVICES

EISENHOWER ARMY MEDICAL CENTER
VETERANS AFFAIRS MEDICAL CENTER, AUGUSTA

DEMONSTRATION PROJECT OUTLINE

1. **BACKGROUND.** Eisenhower AMC and the VAMC, Augusta is embarking on a Joint Venture for Shared Services (JVSS) Project as outlined in the Concept of Operations dated 30 April 1993. This joint venture is possible through the unique situation of two existing federal medical centers co-located in Augusta, Georgia which have capabilities and requirements which can be mutually supporting. As outlined in the Concept of Operations the goal for the JVSS is to provide service improvements for all beneficiaries and operational cost containment while progressing toward congressional goals in the area of cooperative federal health care management. As efforts have progressed with initial implementation of the JVSS project specific impediments to efficient operations have been identified. Efforts are underway to identify target areas for process improvement which will enable more effective joint operations. With the development of the scope and requirements of formal project demonstration status from both the Department of Veterans Affairs and Department of Defense it is critical to identify the specific issues necessary to implement meaningful change in the current business practices. This paper outlines the target areas for process improvement and the scope of the changes in current business practices and limits to current authority which will require action under formal Demonstration Project status.

2. **PURPOSE.** This document will describe the scope of the requirements for the JVSS through a Demonstration Project. The specific operational areas that are expected to be affected will be outlined with examples of how initial implementation is constrained by existing processes. These constraints addressed below come from a variety of Federal and Civilian regulatory agencies. In some cases there will be simple measures to adapt to this new environment, in others the changes may require significant time and effort. As additional experience is acquired in this JVSS project additional areas and examples will become apparent. The purpose and benefit of the demonstration status will be the development of new processes and procedures to rectify or improve existing operating methodologies, facilitating the capability to conduct joint Federal operations for health care delivery throughout the Departments of Veterans Affairs and Defense.

3. **DEMONSTRATION PROJECT.** The general areas listed below are specific examples of identified topics that can offer improvements in the operation of a JVSS project. This list is not all inclusive but represents an initial phase of target areas for a JVSS demonstration project. Additional experience in the operation of a JVSS project with necessarily identify new target areas for of improvements as well as increasing the specific level of detail in these

identified areas. Whenever possible specific examples are cited below. In many cases the details regarding the specific relief or the nature of required change are not obvious at this time and will be, by necessity, developed through the JVSS task force implementation process.

A. GRADUATE MEDICAL TRAINING. Currently the VAMC Augusta has a Type A affiliation agreement with the Medical College of Georgia (MCG). EAMC has a gratuitous agreement for training with MCG. The only available process for affiliation between VAMC and EAMC is the establishment of Type B affiliation agreements for each specific clinical service. In order to facilitate the exchange of house staff between all three institutions especially for clinical services operating a JVSS, authority is necessary to establish an umbrella agreement which will cover all permutations of training at any affected facility.

B. PROVIDER CREDENTIALING. Currently the VAMC and EAMC conduct independent credentialing utilizing a similar process. Certain documentation is exchangeable and accepted, other information by current guidelines requires duplicative searches. Authority to identify additional data which can be shared as verified without requiring additional expense and time will facilitate the credentialing process. Separate credentialing offices will be maintained but the possibility of creating a uniform database for the credentialing process will be addressed.

C. BENEFICIARY ELIGIBILITY. Currently the Department of Veterans Affairs and Department of Defense partially share a beneficiary population with varying entitlements. Data systems exist in each system to verify eligibility for health care services. Many issues in this area will require phased changes. Initially improved access to data systems and the ability to identify, enroll and register beneficiaries receiving services under JVSS projects is necessary. Eventually identifying a system to clearly identify benefits packages for all beneficiaries and make accession of services transparent for JVSS operations will improve the delivery of health care by both systems.

D. RECORDS MANAGEMENT. Currently there are duplicative systems for management of outpatient and inpatient records. Improving the management of all records to improve appropriate access to the clinical information and decrease the duplication of paper and electronic information will result in significant savings of time and expense. Clarification of JCAHO requirement for records keeping will be necessary to identify which data need to be stored at each institution for JVSS patients. Improved processes for exchange of existing records will also be necessary for all patients who access both systems.

E. CLINICAL DATA SYSTEMS. The Department of Defense Composite Health Care System (CHCS) was developed specifically to be compatible with the Veterans Affairs Decentralized Hospital Computer Program (DHCP). There are no established bridges developed to share electronic data between CHCS and DHCP. This JVSS project is an ideal endeavor to provide an appropriate clinical arena for the development of effective clinical data sharing via these computer systems.

F. PERSONNEL MANAGEMENT. Effective operation of the JVSS project will require a relatively transparent system to share existing personnel resources and a streamlined process to acquire additional personnel necessary to the operation of JVSS services. Authority to detail military and civilian personnel to support established JVSS services as well as the ability to develop uniform personnel acquisition methodology will benefit JVSS project operations.

G. WORKLOAD MANAGEMENT. Existing process for workload management and workload accounting do not address all the permutations of the work performed by providers from both systems for beneficiaries of both systems. Appropriate accounting processes and the ability to identify all JVSS workload will be necessary to track the benefits and expenses of this project. Additionally each health care system must recognize all workload in regard to future staffing and resourcing. This is especially apparent for personnel staffing requirements and Operating Room resourcing.

H. FINANCIAL MANAGEMENT. The overall purpose of the JVSS project is to improve health care delivery and control cost. The savings will occur in numerous areas and a system to identify all costs and expenses is expected to be complex. Initially the accounting for JVSS services will be through a Business Plan approach which will identify the scope of the services provided through the JVSS against the additional expenses incurred by each institution. Each JVSS service is expected to produce mutual benefit of varying degrees when the total care delivered to the separate beneficiary population is compared to the specific institutional expenses with and without the JVSS.

I. THIRD PARTY INSURANCE. Both institutions are conducting aggressive and successful Third Party Insurance Collection programs. The guidelines for collection for patients involved in JVSS services will need to be established. It is expected that revenue from JVSS patients will be utilized to directly support the JVSS project in line with existing central requirements.

J. CHAMPUS/CHAMPVA REIMBURSEMENT. Department of Defense beneficiaries and some Veterans Affairs beneficiaries have entitlement programs to subsidize direct care services. Establishing the capability to utilize JVSS services as partnerships within these programs offers the potential to recapture a significant proportion of these expenses. Facilitating the ability to create CHAMPUS/CHAMPVA recapture initiatives, facilitate billing, and improving control through non-availability statement management will integrate these costly programs with the JVSS operations. Concepts such as Regional support, Centers of Excellence, and Specialized Treatment Services will all enhance the benefit achieved through JVSS services.

K. LOGISTICS SUPPORT. Joint Venture operations will by necessity involve equipment and supplies that currently exist in each system as well as additional material required by the JVSS project. Clear lines of accountability and management are necessary for hand receipt and property book activities. Medical maintenance activities also require

coordination for maintenance of shared equipment as well as offering advantages in the area of combined operations. Economies of scale are clearly possible within the property and supply acquisition arena as well as possible improvements in inventory requirements through development of enhanced supply capabilities. Co-management of these responsibilities will improve operations and simplify financial accountability.

L. CONTRACTING. Existing contracting activities operate independently. Authority to utilize the contracting resources necessary to support a JVSS service independent upon the location of the services or equipment, or category of beneficiary involved. Streamlining of existing contracts to serve both institutions when possible will also achieve economies of scale as well as eliminating duplicative efforts.

M. PATIENT SERVICES. Specific patient services are necessary for the efficient operation of a health care system. Discharge planning, long term patient management, chronic care operations, home health care, and case management all are examples of areas in which health care quality and cost have a profound impact as an alternative to management of these patients as inpatients. Coordination of these services are necessary for JVSS service patients, but greater benefits are possible through universal cooperation for all patients in this arena.

N. ANCILLARY SERVICES. Policy and procedures for Laboratory, Radiology, Pharmacy, and other ancillary support is necessary for JVSS service patients. Clinical data sharing, records keeping, and support for patient access will need to be as transparent as possible for these JVSS patients. Additionally, combination of these areas in direct support for general operations will again yield benefits through economies of scale and reduced duplicative efforts when feasible.

O. STAFF EDUCATION AND TRAINING. With combined clinical operations the ability to ensure adequate exposure to clinical services and procedures combined at one location will require ongoing efforts in education and training. Nursing personnel, OR staffs, resident house staff, and staff physicians will need the appropriate cross training to maintain proficiency no matter where the specific services or procedures are provided. Licensure, certification/recertification requirements, and training program curricula will need to be evaluated critically in areas of JVSS service relocation. Additionally, identification of areas amenable to combined or coordinated training will provide resource savings.

4. **SUMMARY.** The progress and potential of a Joint Venture for Shared Services Demonstration Project will be in the capacity for an operational environment to have input into the definition of guidelines, policy, and programs. The existing initiatives between Eisenhower Army Medical Center and the Veteran's Affairs Medical Center, Augusta offer a unique foundation for the development of prototypes for DoD/VA sharing programs. Identification and documentation of the successes and problems encountered through a joint demonstration project will provide benefit for all Medical Facilities in both systems.

Statement of Kenneth E. Cox, Director, Operations and Management Support
Office of Assistant Secretary of Defense (Health Affairs)

Mr. Chairman, I am Kenneth Cox, Director, Operations and Management Support in the Office of the Assistant Secretary of Defense (Health Affairs). One of my most important responsibilities involves development and oversight of resource sharing policy with other federal health agencies. The Department of Defense is particularly pleased to have the opportunity once again to express its position on DoD/VA health care resources sharing. The Department places enormous value on its sharing partnership with the Department of Veterans Affairs. As an indication of the success of our mutual relationship, during Fiscal Year 1993, there were approximately six hundred sharing agreements in effect representing more than three thousand shared services. Due to the great combined size and resources of the VA and DoD medical systems, as well as the geographic dispersion of the agencies' facilities, opportunities for sharing resources and saving Federal dollars are many and significant. More than ever before, sharing among federal health care providers is relevant and necessary to support the cost-effective delivery of quality health care for federal beneficiaries.

The primary initiative within the Military Health Services System today is to position itself for national health care reform through implementation of managed health care delivery on a regional basis - a program we call TRICARE. TRICARE will enable us to be responsive to the needs of patients who are better informed, have higher expectations, and are more resourceful in obtaining services than in the past. We must be prepared to provide access to care, in a cost effective manner, with no degradation in the quality of that care. Within each region, a Lead Agent has primary responsibility for health care delivery throughout that region. The Lead Agent will coordinate planning, build integrated health care networks, and serve as a referral agent for a broad system of care within the geographic region. For the first time,

beneficiaries living outside of the immediate area surrounding a military treatment facility will have a responsible organization to assist in meeting their health care needs.

In DoD, we clearly see the potential for increased roles for VA in this environment. In areas not served by a DoD medical treatment facility, VA may offer cost effective care for selected services on a space available basis. Initial contact, negotiations, and ongoing interaction will be facilitated by the existence of a local DoD Lead Agent for each regional area. Significantly, due to increasing base closures, the number of such geographic areas not served by DoD medical treatment facilities is growing. VA/DoD sharing will continue, and in fact, will be integral to the managed care health care delivery system which the Department of Defense is implementing.

The VA and DoD have wholeheartedly entered into the spirit of the 1982 sharing legislation. The program has shown continued annual growth. In 1984, there were 102 combined VA and DoD facilities with sharing agreements. That number grew to 332 in FY 93. Over 140 VA facilities have operating agreements with 191 military medical facilities and other military commands. In FY 93, there were approximately 3,512 services shared - a 10 percent increase over the previous year and I expect the program to continue to grow. The types of services covered by sharing agreements range from major medical and surgical services, laundry, blood, and laboratory services, to unusual specialty care services. In FY 88, VA/DoD sharing resulted in an estimated cost savings of $9 million, growing to $14.9 million in FY 92.

Education and training agreements between the departments increased in FY 93 from 182 to 215. These agreements typically involve an opportunity for training in return for enhanced staffing and are between VA medical centers and reserve component units. Under a typical agreement, a VA medical center provides space for

weekend training drills. In return, reserve personnel serve as supplemental staff. For example, the VA Medical Center in Tampa, Florida, has training agreements with Army, Navy, and Air Force Reserve units. An average of 25 reservists train at Tampa on weekends while simultaneously supplementing VA staff. Reservists training at Tampa include physicians, nurses, and medical technicians. Training occurs in medical services, shock trauma, aeromedical evacuation, disaster preparedness, surgery, psychiatry, pathology and administrative services.

The National Defense Authorization Act, FY 1990, authorized DoD to reimburse VA Medical Centers for services provided to the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) beneficiaries. Subsequently, the Veterans Health Care Act of 1992 expanded the sharing authority and further clarified VA authority to treat CHAMPUS beneficiaries. A Memorandum of Understanding facilitating implementation of these laws was signed by the Secretary of Defense on February 3, 1994, and the first sharing agreement under the MOU has been negotiated with Asheville, North Carolina VA medical center.

A major area of VA/DoD sharing is joint venture construction of health care facilities. Where it is in the best interests of the government, the VA and DoD have been working closely together to develop joint ventures. The first fully operational joint venture is the facility at Kirtland AFB in Albuquerque, New Mexico. This is a joint undertaking of which all can be proud. The Air Force is operating a wing in the Albuquerque VA Medical Center. The Air Force also operates a comprehensive health care clinic and dental clinic adjacent to the hospital. Through this sharing effort, the Air Force avoided approximately $10 million in construction costs and is producing additional savings through multiple sharing agreements within the facility.

Another first is a new 129-bed hospital under design at Nellis AFB. The $75 million FY 1990 Federal Medical Facility built to replace the Nellis Air Force Base Hospital is near completion. Opening is scheduled for July 1994. Air Force will operate the 129 bed facility but VA will staff its 52 beds. VA will continue to operate its Las Vegas outpatient facility. The Air Force and the VA project estimated annual savings of almost $24 million and approximately $7 million respectively. Joint ventures are also being evaluated at the following locations: Travis AFB, California; Elmendorf AFB, Alaska; East Central Florida; Fort Sill, Oklahoma; Fort Bliss, Texas; Tripler Army Medical Center, Honolulu, HI; and Goodfellow AFB, San Angelo, TX. Early identification of requirements and planning for health information sharing at joint venture sites is an area of particular importance, and the Departments are currently developing an approach to evaluate business processes at joint venture sites.

VA and DoD collaborate in numerous research projects. In FY 93, investigations included research in traumatic brain injury, post-traumatic stress disorder, alcoholism, AIDS, spinal cord injury and sensory impairments. This program complements the research programs of the two Departments. This Fiscal Year $20 million was appropriated for cooperative medical research, and the "Mystery Illness" among veterans of the Persian Gulf War is a priority research area.

The DoD health care community recognizes that it must develop creative and innovative approaches to health care delivery while retaining the flexibility to respond to the demands of its readiness mission and health care reform. In that light, DoD is already collaborating with VA in pursuing new sharing models to assist each Department in serving its beneficiaries in a rapidly changing health care environment.

Statement of Arthur S. Hamerschlag, Director, Medical Sharing Office, Veterans Health Administration, Department of Veterans Affairs

Mr. Chairman, I am delighted to have the honor of appearing before you today to discuss VA Medical Resource Sharing issues. As Director of the Medical Sharing Office in the VA Central Office, I have policy and oversight responsibilities for VA's Sharing Programs: VA-DoD Sharing, Sharing of Specialized Medical Resources, and Scarce Medical Specialists Services. In general, these various authories are designed to 1) enable the VA to improve the quality and availability of services it provides to veterans, 2) save VA and DoD money by allowing them to buy services from and sell services to each other, and 3) allow VA to earn dollars by sharing (or selling) medical resources with (or to) other health care providers. VA endorses these worthy objectives and has made good use of these authorities over the years.

My job in Washington is to provide policy guidance, oversight, technical assistance, and encouragement to VA Medical Centers who decide how and when to use these authorities. Expressed another way, we try to put a sharp tool in the hands of local managers and they decide how best to use it. Augusta VAMC provides an excellent example of how these tools can be used with DoD and our affiliated Medical Schools.

From a national perspective, VA and DoD have approximately 600 active sharing agreements, covering some 3,500 shared services. Just a few examples of these shared services would include laundry, dentistry, radiology, MRI's, CT scans, specialized burn treatment, and training agreements with medical reserve units. VA and DoD charge each other mutually agreed prices for the services they provide. VA Medical Centers keep the proceeds received for the services provided. Over the past five years, VA earnings have grown from $19.9 million (FY89) to $35 million (FY93). Over the same period of time, VA payments to DoD have grown from $3.5 to $12 million. In addition, many agreements may call for bartered or traded services involving no direct payments.

Another form of VA - DoD sharing is joint ventures. The first of these is in Albuquerque, New Mexico, where VA and the Air Force jointly occupy a single health care facility and have a wide range of shared services. Other joint ventures are either planned or are under discussion for Las Vegas, Nevada; Anchorage, Alaska; El Paso, Texas; Honolulu, Hawaii; Lawton, Oklahoma; Brevard County, Florida; and Travis AFB in California.

VA has approximately 246 Specialized Medical Resources Sharing agreements in place. Typical services that VA acquires under this program are radiation therapy, MRI, CT scan, mammography, cardiology, and cardiac surgery. Since FY 89, VA purchases under this program have grown from $37.7 million to $45 million in FY93. Examples of services VA provides under this authority include diagnostic radiology, clinical laboratory services, podiatry, and general medicine. Payments received under this program have grown from $11.6 million in FY 89 to $19.3 million in FY 93. In many instances, a VA medical center may buy one set of services from its affiliated medical school and sell a different set of services to the school. To the extent the payments offset each other, out of pocket expenses are limited for each partner. In rural areas, this authority allows VA medical centers to share their expertise and excess capacities with other local providers to the general benefit of health care in the area. Again, any such payments received are kept by the VA medical center providing the services.

Mr. Chairman, up to this point I have focused on how these authorities are being used at the present time. You have requested that we address how these authorities might be used in the future, as we move toward Health Care Reform.

Secretary Brown has laid out a clear, challenging vision for the future of the veterans' health care system. Under President Clinton's Health Security Act, all veterans and their families would be able to enroll in a VA Health Plan. At the same time, veterans would be free to choose other providers of care. VA would compete in the marketplace, like other health care systems, on the basis of quality, cost, and accessibility. It is an exciting and challenging vision.

In this environment, VA will need every possible tool to hold down costs, maximize income, attain the highest possible quality of care, and provide the greatest possible access to its services. In this most demanding future, I believe VA's sharing programs will be essential tools for our local health care managers.

I would like to offer a hypothetical illustration. Suppose a VA Medical Center and a DoD Medical Treatment Facility (MTF) are closely located, as are the Augusta VAMC and the Eisenhower Army Medical Center. Under health care reform, the two facilities might agree on various levels of cooperation. One approach might be to establish separate health care plans, but to set up a single network of clinics available to members of both plans. The two facilities might then decide to jointly plan their specialty care and sell services back and forth, like Augusta VAMC and the Eisenhower AMC are planning to do, to hold down costs and to maintain high quality. For example, one facility might provide all specialty pediatric care, while the other might provide open heart surgery. Of course, where demand justifies it, both facilities might offer a service. The nature and degree of cooperation could vary widely, depending on local circumstances. It is important that our local health care managers have the ability and freedom to make these types of decisions.

Of course, many VA medical centers are affiliated with medical schools which are integral parts of our health care system. The medical schools also might want to set up their own health care plans. Again, VA medical centers must have the ability to work with their affiliates in a wide range of innovative ways, perhaps in ways none of us can even foresee right now, as we move toward health care reform.

Mr. Chairman, VA faces a number of complex and challenging issues as we move toward health care reform. To prepare for these challenges and to achieve Secretary Brown's vision, VA has recently undertaken a broad-based planning effort. This strategic planning process involved hundreds of individuals from our medical centers, as well as Central Office, and included representatives from many Veterans Services Organizations. As a result, VA is developing an implementation plan covering a wide range of issues, including sharing programs. The draft plan will soon be presented to VA's top officials and ultimately to Secretary Brown.

In summary, Mr. Chairman, VA's sharing programs are important tools which we use to carry out our mission of providing high quality health care to America's veterans.

Mr. Chairman, I appreciate the opportunity to appear before your panel here today and would be pleased to answer any questions you may have.

TESTIMONY OF
JACK H. STEED
PRESIDENT, AIR FORCE
ASSOCIATION OF GEORGIA

BEFORE THE
SUBCOMMITTEE ON HOSPITALS
AND HEALTH CARE
OF THE
HOUSE VETERANS AFFAIRS COMMITTEE
IN AUGUSTA, GEORGIA
ON FRIDAY, FEBRUARY 18, 1994

FOREWORD

The Eisenhower Army Medical Center is definitely needed regardless of whether Defense installations in Georgia and neighboring states are downsized or closed. The Air Force Association of Georgia position supports not just the retention of the Eisenhower Army Medical Center and other health care facilities but the expansion of their capabilities where needed. The following testimony will address the deep concern of military retirees concerning the lifetime health care promises made to them and on which they believe the government is reneging. The Eisenhower Army Medical Center is a case in point.

INTRODUCTION

Most retirees believe they were promised lifetime military medical care by their commanders, recruiters and retention personnel and the government in general. In fact recruiting literature dated as recently as 1991 and being used now states:

> "Health Care is provided you and your family members while you are in the Army and for the rest of your life if you serve a minimum of 20 years of active federal service to earn your retirement".

Retirees are distressed that the Department of Defense (DoD) has not adequately assumed its responsibility for the health care of their lifetime employees - military retirees. Retirees believe that they are entitled to lifetime military medical care by first earning it by 20 to 35 years of military service and second by paying for it with mandatory Medicare deductions from their pay. At age 65, just when they need medical care the most, they are told, based on arguments of DoD attorneys that their military medical benefit can be provided only on a space available basis and they cannot even be treated at a military or veterans medical treatment facility and have medicare reimburse the facility for services rendered. Their bewilderment and frustration can be well understood.

UNDERMINING OF THE ALL VOLUNTEER FORCE

The Armed Forces are being drawn down too quickly and cut too deeply to support DoD's simultaneous two war scenario. This strategic plan cannot be adequately supported by the forces approved in the Bottom Up review. Promises made by the government to recruit and retain the men and women to provide the defense of the nation, both in time of war and peace, appear to be forgotten by many members of Congress, the Administration and the Department of Defense. It is clear that military retirees and families who have played a major role in the success of the ALL VOLUNTEER FORCE in the past are now becoming embittered as they find that the promises made to them years ago are not considered a legally enforceable contract and that the currently largely non-veteran White House and Congress have forgotten or simply do not understand or care about the promises made by previous Administrations and Congresses. If not corrected, these broken promises will result in the loss of retiree support for our volunteer force and we will eventually not be able to man the force with high quality, well educated personnel even at the lower levels.

Retirees are expressing a growing feeling of disaffection. Many are no longer willing to advise high quality potential recruits and retention prospects to consider a military career because they perceive that the Armed Forces, as an employer, has a clear

history of not keeping keeping promises. This attitude of military retirees who helped build the volunteer force from the hollow force of the l970s and l980s, unless reversed, will eventually dismantle the high quality of the Armed Forces because high quality personnel at any significant strength levels will avoid military service.

CLINTON NATIONAL HEALTH PLAN

While we generally support the DoD plan for implementation of the Clinton National Health Plan - we cannot fully support it at this time because the plan treats under age 65 beneficiaries and the over 65 beneficiaries as totally separate categories. All retirees, family members and survivors, regardless of age, should be included in a single group for medical care, without internal priority arrangement and without regard as to how DoD plans to fund the care. This certainly appears to be a blatant case of age discrimination

The rationale that active duty beneficiaries have been significantly reduced by the drawdown of active duty personnel and therefore can reduce military medical personnel without loss of health care services does not meet the test of credibility and reality. This is true because the majority of the military personnel released from the service due to the drawdown are young, healthy personnel requiring little medical care. On the other hand, the older, married NCOs and Officers with families remain ands still are beneficiaries of the Military Health Care System, and those who have retired early and their family members continue to be eligible for care in military treatment facilities or under CHAMPUS. These planned medical personnel reductions will greatly reduce the capability of medical personnel to care for these beneficiaries at the very same time medical facilities should be gearing up to take over the Lead Agent role of the Military Health Plan as it implements its responsibilities under the President's Health Plan.

BASE CLOSURE AND REALIGNMENT

The prospect of a base closure, realignment and downsizing is one of the most difficult issue facing many communities today. The base is often an integral part of the community and has a very significant impact on the economy and employment. The base also provides many needed services to retirees and their families. Thus the closure or prospect of closure of a major base is traumatic, often throughout an entire region.

In his report to the Base Closure and Realignment Commission, Secretary of Defense Les Aspin clearly defined the rationale for closing bases as a consequence of the declining defense budget and conformance with the Six Year Defense Plan. He further explained numerous assistance and transition plans available to active duty military members, civil service employees, private sector employers and local communities. Lacking in the Secretary's comments was any mention of the impact on the options available to the sizable military retiree community.

Military retirees often choose to live near a base because it offers them the opportunity to take advantage of benefits earned during a military career. These benefits include access to medical treatment facilities, including pharmacies, commissaries, exchanges, morale, welfare and recreation services. The availability and use of these services often saves the military retiree living on a reduced, relatively fixed income a considerable amount of money during the year.

THE MOST IMPORTANT BENEFIT

The most important benefit, and the one most cited by retirees, is continuing access to medical care. This access is promised by law and tradition and dates back more than 200 years. Prior to the l950s, the promise to provide military medical care was not questioned because throughout their military careers and in retirement, medical care was provided in military treatment facilities (MTF) for personnel authorized to use those facilities. In l956, when there were 6.4 million beneficiaries, Congress made space available care in MTFs available to active duty dependents.

Today, however, there are some 9.5 million beneficiaries. Retirees and their dependents comprise 50 percent of this group. As our Armed Forces are reduced and military installation and military treatment facilities are closed, space available care is becoming more scarce. We do not believe Veterans Hospitals, as presently configured, are the answer. They are often under staffed and the hassle associated with obtaining appointments and medical care just aren't doing the job. Too often waits for appointments are ridiculously slow, sometimes up to six months. For example, there is a 94 year old retiree in the Houston/Peach county area who has been trying to get a hearing aid for about one year. This is another reason Veterans Hospitals are held in such low esteem by many retirees. The establishment of out-patient clinics where sizable numbers of retirees are located would help ease the appointment problem and restore some credibility to the Veterans Hospitals.

CHAMPUS

The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) program was enacted in l966 as a response to the increasing numbers of retirees and dependents and the shortages in the military medical staff. Medical care on a space available basis was authorized with CHAMPUS as a backup. The enactment of the CHAMPUS program and its follow-on enhancements is an after-the-fact admission that the Defense Department has a major responsibility for these retiree beneficiaries and is honor bound by its recruiting and retention promises.

Loss of CHAMPUS benefits at age 65, just when they need it most, is a major concern among retirees. It is a great inequity that military retirees, their families and survivors are the ONLY Federal government retirees who lose their entitlement to a medi-

cal benefit from their employer at age 65 upon becoming eligible for Medicare. We strongly believe that the Department of Defense should not be permitted to drop all legal responsibility for medical treatment of over age 65 military retirees. Legislation is URGENTLY needed recognize the explicit and implied promises and provide a defined, lifetime benefit for retirees and their families and their survivors regardless of age!

We fully realize the need to close facilities no longer in our nation's best security interest. Many have closed and more will close in the future. The Air Force Association believes that a host of health care delivery programs for retirees - some existing, some developed but not funded and others being and others being evaluated should be studied in detail. The result of this careful study should determine which programs meet the needs of retirees. To be successful, these programs must be affordable to the government and the retiree alike.

The Air Force Association applauds the 102nd Congress for recognizing the promise of lifetime medical care, the most crucial and necessary post-retirement benefit earned by military retirees. In a "Sense of Congress" resolution, contained in section 726 of the National Defense Reauthorization Act for Fiscal Year 1993 (Public Law 102-84) Congress said in part:

"Sense of Congress Resolution

"It is the sense of Congress that:

> Members and former members of the uniformed services, and their dependents and survivors, should have access to health care under the health care delivery system of the uniformed services regardless of age or health care status of the person seeking health care...
>
> The Secretary of Defense, the Secretary of Health and Human Services and the Secretary of Transportation should continue to provide active duty of the uniformed services with free care in medical treatment facilities of the uniformed services and to provide the other personnel referred to in paragraph (l) with health care at reasonable cost to the recipient of the care...
>
> The Secretaries ... should examine additional health care options for personnel referred to in paragraph (l) including, in the case of persons eligible for Medicare under Title XVII of the Social Security Act, options providing for:
>
> (A) the reimbursement of the Department of Defense by the Secre- of Health and Human Services for health care services provided such personnel at medical treatment facilities of the Department of Defense; and

(B) the sharing of the payment of the cost of contract health care by the Department of Defense and the Department of Health and Human services, with one such department being the primary payer of such costs and the other such department being the secondary payer of such costs."

MEDICAL CONSIDERATIONS

We agree with the Congress and respectfully request that the Committee consider the following proposals for health care and other services which include prescription drug benefits, transitional health care services, public information programs, CHAMPUS reforms and review of the Federal Employee Health Benefit Plan (FEHBP).

We urge the Committee to seek approval of the Administration to lift, where deemed necessary, the ban on the publication, distribution and implementation of new Federal regulations. This action is crucial to the success of previously approved and funded programs, such as the mail order pharmacy and retail pharmacy programs at base closure sites. Our members tell us the pharmacy benefit can make a difference between POVERTY and a reasonable quality of life. Given the current cost of drugs this is easy to understand. For example, maintenance drugs for a patient with a cardiovascular condition can cost in excess of $800 per month.

We further urge you to support the joint DoD/Health Care Financing Administration (HCFA) marketing of HMOs for DoD Medicare eligibles. This excellent, negligible cost, information distribution program provides retirees with easy to read, comprehensive information on health care alternatives, many available at no cost.

This effort is principally one of marketing Medicare-approve health maintenance organizations (HMOs) to DoD Medicare beneficiaries and general information sharing. The Office of the Assistant Secretary of Defense for Health Affairs (OASD/HA), through a contractor, mails out information to beneficiaries in the service area defined by ZIP codes. Beneficiaries are encouraged to contact HMOs and the nearest health benefit advisors for additional information. This program is a low risk initiative and one that offers a significant service to beneficiaries. The end result is assistance to the HCFA in proliferating HMOs for Medicare support. Greater use of HMOs will reduce and contain medical costs for the government and retiree alike.

There are also numerous CHAMPUS Reform Initiative (CRI) Programs now being developed, tested and evaluated at various sites around the country. The Association believes these tests, developed after years of intense study and measurement, offer the promise of delivering quality health care services to military retirees both under and over age 65.

To date, CRI has proven to be highly popular with military beneficiaries, especially due to improved access to care and quality services. Initial studies by the RAND Corporation show that CRI has experienced higher utilization rates than is forecast. If this correct, the increased efficiency of CRI administration will be necessary by utilizing "gatekeeper" providers to control access to primary care services.

Another reason for increased utilization may be the difficulty many users have in contacting and in scheduling and appointments at MTFs. The increased use of automated telephone and computer systems should help in the scheduling and appointment tasks. Along with easing the scheduling and appointment problem, attention also should be paid to streamlining the claims process with standardized forms and procedures.

The Federal Employee Benefit Plan (FEHBP), a program already in being, is highly regarded by analysts in and out of government. Military retirees are the ONLY group of federal retirees who currently do not have access to FEHBP. They are the ONLY group of retirees who lose their major health benefit program at 65; that program being CHAMPUS. Combining FEHBP with MEDICARE for those retirees over age 65 WOULD provide comprehensive care and would increase substantially the eligible pool thus affording the government the opportunity of negotiating even more competitive commercial contracts. FEHBP also offers a key element of need to retirees -- comprehensive coverage for prescription drugs. We recognize that many in the military medical treatment community have reservations about the applicability of FEHBP for military retirees. This program does, however, have outstanding features worthy of further review and consideration.

One of the services most difficult recruiting challenges today is in the medical professional specialty area. The ability to recruit, train and retain highly qualified medical professionals is the key to the services' ability to respond to national security requirements. Information received from the Office of the Air Force Surgeon General, training is most effective when medical professionals have the opportunity to treat patients across the full spectrum, from pediatrics to geriatrics.

With this issue as a major concern, the Association believes that ELEMENTS of the Federal Employee Health Benefit Plan, known FEHBP, may be worthy of study and consideration.

CONCLUSION

Continuing to offer needed and EARNED benefits to retirees is a complex issue especially where bases have closed or are closing. The Association applauds the Committee's interest in trying to find answers where there no easy answers. We really appreciate your efforts in grappling with these tough issues. As you do, we hope you will remember that military personnel have been indoctrinated and trained to be non-political. They are not a huge block of votes that have been politicized and are not politically organized. That is why they have always looked to Congress to champion

the military. Congress has done this in the past because many having "been there" understood the military and the peculiarities of military life. But the number of those who have "been there' are dwindling and what had been taken for granted in the past cannot be counted on today. Congress has been our "union" and our "protector". When that fades away, then the dedication, loyalty and patriotism as we know it today will also fade away. The future of service to country, our future, is in the hands of Congress. May its hands always be strong and gentle for the members of the uniformed services and their families. And, please remember that your constituency, in this regard, extends far beyond the district you represent.

The foregoing testimony supports the essentialness of the Eisenhower Army Medical Center in providing necessary health care to active duty military personnel, retirees and their families in this state and elsewhere. Closure would cause a catastrophic impact upon these individuals, a great expenditure of time and money by these individuals and the government in order to reach more distant health care centers. In fact, closure would exasperate the so-called "health care crisis" in America.