

HEARING ON VA/DOD SHARING

HEARING
BEFORE THE
SUBCOMMITTEE ON
HOSPITALS AND HEALTH CARE
OF THE
COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES
ONE HUNDRED FOURTH CONGRESS
FIRST SESSION

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HEARING ON VA/DOD SHARING

WEDNESDAY, OCTOBER 18, 1995

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

The subcommittee met, pursuant to call, at 9:30 a.m., in room 334, Cannon House Office Building, Hon. Tim Hutchinson (chairman of the subcommittee) presiding.

Present: Representatives Bishop, Clement, Mr. Smith of New Jersey, Edwards, Quinn, Stearns, Ney, Fox, and Flanagan.

OPENING STATEMENT OF CHAIRMAN HUTCHINSON

Mr. HUTCHINSON. Good morning. The subcommittee will come to order. A couple of announcements to the subcommittee. First of all, we have a card from all of us on the subcommittee to our colleague, Congressman Tejeda, who we all know is going through a lot of physical challenges right now and certainly needs our prayer, and our encouragements, so we will be passing this around this morning for everyone to sign to him.

I'll also announce that the subcommittee will be having an oversight hearing regarding the Columbia, MO VA Hospital situation and the unexplained deaths that occurred at that VA hospital and how dysfunctional management may have contributed to that very sad situation. That is scheduled for October 25 and I want the members to be aware of that.

The subject of this morning's oversight hearing is VA/DOD sharing and the related issues of the joint ventures and the TRICARE program. The sharing program was established by Congress in 1982. The guiding principle of the program was to maximize utilization of Federal health care resources to sharing between these two departments. Congress recognized that sharing offered opportunities that would be beneficial to both departments and would reduce costs to the Government by minimizing duplication and the underutilization of resources. The program covers any related hospital service.

During the last fiscal year, the most common types of agreements were for diagnostic services such as clinical pathology, CT scans and nuclear medicine. Exchanges of medical staff are widespread. Agreements also cover such diverse areas as transportation, equipment repair and police protection. Since the implementation of the 1982 program, seven distinct areas of sharing have evolved. They are purchasing services, joint ventures, which we will explore today, education and training programs, where Reserve

units train and supplement VA medical center staffs, Armed Forces medical regulation office—through this arrangement the Air Force provides air transport to veteran patients around the country. Five, health information sharing through a Federal information sharing work group coordination council. This group focuses on identifying information resources and trying to develop solutions to technological and information differences between the two departments. No. 6, advance technology. This program supports the purchase and joint use of sophisticated medical equipment such as PET scanners and Cyclotrons. No. 7, CHAMPUS VA implementation. This issue, plus the integration of VA into the new TRICARE model will be explored during today's hearing, the subject that has interested me a lot, coming into Congress and of which I have little knowledge. I very much look forward to the testimony today.

I want to welcome and thank all of today's witnesses. We have an ambitious agenda of four panels this morning and I know that on the Republican side we have a conference called at 10 o'clock. We're going to stay in session here in the subcommittee during that time, but I suspect that some of my colleagues may be gone during that time, so I will explain their absence because of that conference.

The goal of the subcommittee is to gain a broad perspective of the issues facing those who develop, implement and benefit from sharing between these two departments.

Our first panel this morning will consist of representatives from the General Accounting Office. GAO has done extensive work on the issue of VA/DOD cooperation. Their role this morning is to provide an overview of the issue.

To reasonably accommodate all the witnesses this morning, I ask that each of you summarize your remarks in 5 minutes or less and we'll be glad to enter your complete written statements into the record.

I would now recognize Chet Edwards, ranking member for his opening remarks.

OPENING STATEMENT OF HON. CHET EDWARDS

Mr. EDWARDS. Thank you, Mr. Chairman, and in the name of time I will be very brief and would like to submit with your permission my opening statement.

Mr. HUTCHINSON. Without objection.

Mr. EDWARDS. I would just simply like to welcome all of the witnesses here and commend you, Mr. Chairman, for having this hearing. I think it's a very important issue. It's an outstanding group of witnesses. I'm here to listen and to learn.

I do think it's incumbent upon all of us, as we face limited Federal resources, to be creative and open-minded about finding ways to take the same number of dollars and utilize those dollars more efficiently and that applies to the Department of Veterans Affairs and to the Department of Defense, as strong a supporter as we are of those two agencies.

So I look forward from hearing from the witnesses and thank you, Mr. Chairman.

[The prepared statement of Congressman Edwards appears on p. 41.]

Mr. HUTCHINSON. Thank you, Chet. The chair now recognizes Mr. David Baine, GAO's Director of Health Care Delivery and Quality Issues and Mr. Baine, if you would introduce those who have accompanied you today and you're recognized.

Mr. BAINE. I'd be glad to, Mr. Chairman. On my left is Mr. Jim Linz and on my right is Mr. Dave Lewis, both of whom have been involved in this issue for a fair number of years and who helped us put together our preparations for this hearing this morning.

Mr. HUTCHINSON. We welcome you to the panel and thank you for being here. You're recognized. Please continue.

STATEMENT OF DAVID P. BAINE, DIRECTOR, HEALTH CARE DELIVERY AND QUALITY ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, GENERAL ACCOUNTING OFFICE; ACCOMPANIED BY JIM LINZ, ASSISTANT DIRECTOR, HEALTH CARE DELIVERY AND QUALITY ISSUES; AND DAVE LEWIS, SENIOR EVALUATOR, HEALTH CARE DELIVERY AND QUALITY ISSUES

Mr. BAINE. Mr. Chairman and members of the subcommittee, we appreciate the opportunity to discuss the status of Department of Veterans Affairs health care resources sharing with the DOD.

Health resources sharing, which involves the buying, selling, or bartering of health services, can be beneficial to both parties in the agreement and helps contain health care costs by making better use of medical resources. We've been involved in this issue, Mr. Chairman, for probably 15 to 20 years and over that period of time we've conducted a series of reviews that have identified various barriers to increased sharing.

Much of the progress that has been made in expanding VA sharing can be attributed to continued support of this committee in addressing the legislative barriers and encouraging the agencies involved to address administrative barriers.

I'd like to touch on three areas this morning. The first has to do with the evolution of the sharing legislation. VA has been allowed to share with DOD and other Federal agencies for more than 60 years. Initially, Federal hospitals were required to recover the actual costs of services provided to another Federal agency. In 1966, VA sharing authority was expanded to include sharing specialized medical services with its university affiliates. In 1978, we reported that significant barriers discouraged sharing among Federal agencies. These included the absence of a legislative mandate to do so, agency regulations that inhibited sharing and disagreements over how agencies would be paid for services provided.

The first major step in addressing these barriers occurred in 1982 through the enactment of Public Law 97-174, the VA/DOD Health Resources Sharing and Emergency Operations Act. This act gave increased flexibility to local hospital directors to enter into sharing arrangements. It made reimbursement provisions more flexible and allowed facilities to keep part of the reimbursements. Six years later, however, we went back and took a look at the amount of sharing that was going on and found out that there were other concerns and barriers that needed to be addressed, some of them legislative. For example, the law did not allow VA to treat dependents of active duty and required members of the Uniformed

Services and military hospitals were reluctant to refer DOD beneficiaries to VA hospitals because they could not use CHAMPUS funds to pay for the care.

In 1989, the Congress authorized the use of CHAMPUS funds to reimburse VA. Three years later, the Congress gave temporary authority to treat the dependents of active duty and retired DOD beneficiaries.

Despite these congressional actions, differences between VA and DOD over provisions of a memorandum of understanding continued to prevent CHAMPUS beneficiaries from receiving services in VA hospitals. These differences centered mainly on whether VA hospitals would be treated as military hospitals or civilian CHAMPUS providers. Only after the direct intervention of former Chairman Montgomery was a memorandum of understanding signed.

The advent of DOD's TRICARE program, Mr. Chairman, ushers in a new error of VA/DOD sharing likely to supplant the VA CHAMPUS sharing. In June, 1995, VA and DOD completed work on an agreement that allows VA facilities to compete with private sector facilities to serve providers under TRICARE contracts. Like private sector providers, VA facilities will be allowed to apply to DOD's regional managed care contractors to serve as providers and those facilities will be required to meet the same cost quality and utilization review requirements as are any private provider under the term of the TRICARE contract.

I'd like to now turn to a little history of where interagency sharing has gone in the last 15 years. The number of sharing agreements between DOD and VA has increased from about 12 in 1983 to about 150 in 1995. Every VA facility within 50 miles of a DOD facility now has one or more sharing agreements. VA has about seven times as many agreements to provide services as it does to acquire services from DOD. By contrast, VA buys about three times as many specialized services from its university affiliates, as it sells to those affiliates.

We're often asked, Mr. Chairman, as to what the monetary benefits are of sharing agreements and these are often difficult to quantify. You can quantify it in terms of one agreement or another, but to find out what the range is and what the extent of the sharing of services across the country is, is pretty difficult. This is because there is no centralized data base that provides that information. This is something that we're often asked and it's a tough question to answer.

I'd like to touch just for a second, if I could, on some other challenges that we think VA faces as it moves into the TRICARE sharing environment. VA will need to meet the billing, utilization review and quality assurance requirements of CHAMPUS, TRICARE and private sector health plans. This will be a departure from what VA has done in the past.

And as a buyer, VA will need to determine when it is more economical to buy services or provide them directly. In other words, it will need to know the costs involved in providing its own services so it can make good make or buy decisions.

The Asheville Agreement is a start in that direction because the Asheville Center had to set up the billing system and it had to set up a utilization review system acceptable to the CHAMPUS provid-

ers. That seems to us to be a good start toward getting some of the VA facilities in the mode of being able to deal with private sector providers and also with DOD.

In conclusion, Mr. Chairman, we believe that the medical resources sharing offers benefits to both those providing and those obtaining shared services. Although the primary legislative barriers to increased sharing have been overcome, some of the new challenges that I've just mentioned are still on the horizon. I think it will be some time until VA gets a little experience as a TRICARE provider before we'll know whether there's additional need for legislation of any kind or whether this can all be worked out through the contract provisions with the TRICARE contractor.

We'll be glad to take any questions that you might have.

[The prepared statement of Mr. Baine appears on p. 45.]

Mr. HUTCHINSON. Thank you, Mr. Baine. We appreciate your testimony. Since the issuance of the GAO report in October of 1994, has VA complied with your recommendations to actively identify VA services that could be candidates for these kinds of agreements?

Mr. BAINE. My understanding, Mr. Chairman, is that VA and DOD had identified about eight different sites to try to develop an analog to the Asheville agreement that was signed in 1993. It's also my understanding that the agencies decided that for all but two of those sites they would rather wait until the TRICARE contract was put in place to finalize those agreements. So there are two additional sites, I believe, one in New York and one in Indiana, where there's an analog to the Asheville agreement. I hope that answers your question.

Mr. HUTCHINSON. Yes. How would you rate the Department of Defense's degree of interest in sharing agreements and in expanding these kinds of arrangements?

Mr. BAINE. I've been involved in sharing issues for longer than I'd like to recall. And it's been my experience, Mr. Chairman, that the degree of interest in sharing depends a lot on the extent to which cooperation is undertaken by people at the top of the two organizations.

In the case of Dr. Joseph and Dr. Kizer, I think there's been a real attempt to foster enhanced interagency sharing between the two agencies. Having said that, it's also been our experience that much of the momentum for sharing is local and so it also depends on the personalities, the communications between the facilities themselves, in the local communities. So at the top of the organization there can be cooperation and whatever, but if there's not cooperation at the local facility, it's not going to come off. I think you'll find that the degree of cooperation varies from place to place around the country.

There are several instances where it seems to have worked fairly well. Down in Albuquerque, the Albuquerque joint venture is now touted is one of the success stories. The truth of the matter is it took a long time for all the agreements to be worked out for that to come to pass. I think there's one other point we should make in this whole thing. While a lot depends on the leadership and personalities and the communications between the local facilities, there's a lot of cultural issues that have to be overcome to make this work. That's something that I think Dr. Kizer and Dr. Joseph have recog-

nized and are trying to change the culture of both organizations to kind of get away from this notion of we'd rather do it all ourselves. And I think that has made a big difference.

Mr. HUTCHINSON. But if I understand what you've said as far as quantifying savings, we haven't had enough experience yet to do that. There are other difficulties in trying to quantify the savings, being that we've been at this now for to one agree or another for 12 years and yet because of administrative barriers, legislative barriers, cultural barriers, it's expanded very, very slowly and there's nothing you feel that we can do to try to bring down those barriers to bring about more of these arrangements more quickly?

Mr. BAINE. It's our sense, Mr. Chairman, that many of the legislative barriers have been addressed by this Committee and by the Congress as a whole through the legislation that I cited in my testimony. That took a while. When we first got involved in this issue it was 1978. It was 4 years later before any legislation was passed by the Congress to do anything. There were 3 or 4 years before the next improvements were made and it was 2 or 3 years after that that the last improvements were made. It's our sense, however, that most of the legislative barriers have now been overcome. Now it's a matter of an implementation plan. That's the short answer to your question.

Mr. HUTCHINSON. If we could just legislate away cultural problems, right?

Mr. BAINE. That's a little tougher.

Mr. HUTCHINSON. Mr. Edwards.

Mr. EDWARDS. Thank you, Tim. That was one of the primary questions I wanted to ask, if this was more of a legislative problem or an administrative-cultural problem and I think you addressed that.

In terms of any changes in laws, Mr. Baine, is there a need for any changes in fiscal incentives through changes in the law? Are fiscal incentives a problem, a serious problem?

Mr. BAINE. There shouldn't be. I believe there's a different interpretation in VA and DOD with regard to the extent to which and what portion of the proceeds from sharing agreements can be retained at the local facilities. The DOD has decided, I believe, through their General Counsel's Office, that a portion of the proceeds—that portion which relates to the operation and maintenance funds—can be retained by the local facility. But the military pay portion cannot, and therefore there's a front-end adjustment made in the budgets of the facilities.

It was my sense when the initial law was passed back in 1982 that that was sort of taken care of. However, I'm not a lawyer, but that was the interpretation of the DOD General Counsel, as I understand it. VA, on the other hand, allows their hospitals to retain the reimbursements from sharing agreements, and therefore provides that kind of incentive.

Mr. EDWARDS. Okay. You said you don't think we need any more legislative efforts to break down barriers. Do we need any legislative prodding? Is there any constructive way that Congress could prod the VA and DOD into being more aggressive in this area without trying to micromanage their decisions?

Mr. BAINE. I think that's essentially what happened a year or so ago when the Asheville agreement was kind of hung up for one reason or another. Then Chairman Montgomery interceded in that particular instance and it was not 2 months after he interceded that that came to fruition and the agreement was signed and was underway.

Mr. EDWARDS. Very good. Thank you.

Mr. BAINE. So I think the short answer to your question, continuing encouragement if that's the will of this subcommittee or the full committee to do this makes a lot of sense.

Mr. EDWARDS. Very good. Thank you, Mr. Baine.

Mr. BAINE. Sure.

Mr. HUTCHINSON. Thanks, Chet. Mr. Ney, you're recognized.

Mr. NEY. I pass.

Mr. HUTCHINSON. Mr. Bishop.

Mr. BISHOP. I pass.

Mr. HUTCHINSON. Mr. Fox, the gentleman from Pennsylvania?

Mr. FOX. Thank you, Mr. Chairman, I pass.

Mr. HUTCHINSON. All right, are there any other questions of the panel?

Chet, do you have any more? All right, we thank you very much.

Mr. BAINE. Our pleasure, sir.

Mr. HUTCHINSON. The chair now recognizes Dr. Kenneth Kizer, Under Secretary for Health at the Department of Veterans Affairs and Major General George Anderson, the Deputy Assistant for Secretary for Health Services Operations and Readiness at the Department of Defense.

Dr. Kizer, it's good to see you again. General Anderson, we welcome you. Dr. Kizer, you are recognized.

STATEMENTS OF KENNETH W. KIZER, M.D., M.P.H., UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS; MAJ. GEN. GEORGE K. ANDERSON, USAF, MC, DEPUTY ASSISTANT SECRETARY OF DEFENSE, HEALTH SERVICES OPERATIONS AND READINESS, DEPARTMENT OF DEFENSE

STATEMENT OF KENNETH W. KIZER

Mr. KIZER. Good morning, sir. Good morning, members of the subcommittee. I'm pleased to be here to have this opportunity to discuss with you the subject of joint venturing and the sharing of health care resources between the VA and DOD.

Mr. Baine has commented some about the history of the sharing between the two departments, so I'm not going to say anything further about that, although I would correct the numbers that he cited for you. The actual number of agreements between the VA and DOD at this time is 605 for a total of 4,133 different services as opposed to, the much smaller number I think he cited.

As you well know, I am highly supportive of the concepts and underlying principles of VA/DOD sharing and joint venturing. That is the concept of working towards the most efficient use of the taxpayer dollars that support the two institutions.

During my 11-month tenure with VA, I have strongly encouraged our medical centers to expand resource sharing. We have already heard some brief discussion of the memorandum of understanding

that I signed with DOD last June to expand our opportunities as a CHAMPUS provider under the TRICARE program. Indeed, the message that has gone out to our medical centers is that they should all get as involved in the program as they can, recognizing that certain preparatory efforts have to be made if we're going to be a successful player in that arena.

We've also signed agreements for our medical centers at Syracuse and Indianapolis to be CHAMPUS providers. I would note that there has been significant interest in expanding the number of these type of agreement, but pursuant to DOD's request that we work through the TRICARE providers, at this point we only have these two additional individual agreements. Otherwise, we will work through the TRICARE program.

I would also point out, just to put this in some context, that we have hundreds of other sharing agreements with our academic affiliates, as Mr. Baine mentioned. We have a smaller number with the Public Health Service and with local and State government entities. I see sharing and joint venturing as critical to the long-term success and viability of the Veterans Health Care system. Exemplative of that are some of the actions that we have taken in the past few months. As I think you're aware, we signed an agreement with the Juvenile Diabetes Foundation to create centers of excellence for research in diabetes. We have signed memorandums of understanding with the University Health Systems Consortium for technology assessment and clinical benchmarks development. We're currently exploring some opportunities to expand this agreement into other areas. We've signed a memorandum of understanding with the Agency for Health Care Policy and Research for clinical guidelines development. We're discussing a number of opportunities like this with other agencies as well.

I see joint venturing and sharing as a critical element of our future. Having said this, I think I should also express some of my concerns in this regard. I have some concerns about these joint ventures based on my experience in the private sector with mergers of companies, as well as my experience in academia and State government. I think a certain degree of caution is prudent when we enter into these sharing agreements.

There are many potential problems when you try to combine or blend entities that have separate missions, cultures and operating systems. In some cases, these are merely just logistical details that have to be taken care of—i.e., if you're motivated, the incentives are correct and the differences aren't too profound. However, these can be particular issues, e.g., in the case of mission, that can lead to some substantive problems. I want to come back to this issue in a moment.

You talked with the previous witness about culture and legislative issues that have been addressed to encourage sharing. There also is another important quality, particularly with regard to DOD and VA, having to do with our mission; sometimes this can be a barrier. Because the difference in missions between the two departments, i.e., Veterans Affairs being in the health care business, as well as education and research, as opposed to DOD's military readiness mission, can lead us at different fundamental incentives and motivations as we look at these. The health care mission of DOD

is primarily in support of its military readiness mission, and that's not necessarily the same as it is with VA where you're taking care of an older population with multiple medical problems.

Just briefly let me conclude by saying that at least based on my experience elsewhere, as well as with my limited experience so far with the VA, if a joint venture is going to be successful, it has to be designed from the outset as much as possible to assure that the primary purpose of the joint venture is going to be achieved. In the case of running a hospital, whether it is to serve veterans or to take care of active duty military personnel, one would want to insure that whoever is designated as the host, or whoever has the lead responsibility for executing that joint venture, that their primary mission should be providing health care, hospital management and other things relevant in that regard. It is essential that you focus on the most intense needs or the highest acuity patients because it is much easier to provide for those with less intense needs, and fiscally it becomes an issue of working on the margin, if you focus on your highest need as opposed to what may be lesser need patients. If the focus is on those who have less intense need, then it becomes more difficult, and indeed often more expensive, to then go back and focus on those who have higher needs.

Let me just close by saying that having expressed this caution, I think this is an arena that we are fully committed to. It is a good thing. We have had success in the past, and we're going to continue to explore more opportunities in the future. Particularly with a new operational and managerial structure in the department, the incentives really are in place to foster and promote sharing and joint venturing, not only with DOD but with private sector entities, academic facilities and others.

Thank you.

[The prepared statement of Dr. Kizer appears on p. 63.]

Mr. HUTCHINSON. Thank you, Dr. Kizer. General Anderson.

STATEMENT OF MAJ. GEN. GEORGE K. ANDERSON, USAF, MC

General ANDERSON. Good morning. Mr. Chairman, I'm pleased to be here today to express to you and members of the subcommittee the Department of Defense's position on a very important subject, health care resources sharing between the Department of Defense and the Department of Veterans Affairs.

Mr. Chairman, I have a complete statement for inclusion in the record, however, in the interest of time, I will give a summary of that statement.

The Department of Defense views this sharing relationship as one of great importance and is firmly committed to its continuation and strengthening. Dr. Joseph, the Assistant Secretary of Defense (Health Affairs) and Dr. Kizer, the Under Secretary for Health in the Department of Veterans Affairs, have created a strong sharing climate within the departments. Evidence of that is in a recent jointly authored article in *U.S. Medicine* which sets the direction for the sharing relationship through a series of priorities. I have a copy of that article for inclusion in the record.

Since 1982, the two departments have worked hard to generate dramatic increases in sharing and associated cost savings. They have been successful, however, in the effect of base closures on the

number of DOD facilities, diminishing Federal resources and a dynamic health care scene suggest that we should not be planning for the future based on the past.

We, in the Department of Defense, together with the Department of Veterans Affairs, are focusing our joint efforts on our long-range needs and areas of mutual benefit. Joint ventures are included in this planning where they are beneficial.

Today, there are eight joint ventures in various stages of development. Two of them are operational: the eight year old New Mexico Regional Federal Medical Center at Kirtland Air Force Base in Albuquerque, New Mexico and the one year old Nellis Federal Hospital, 129-bed community hospital at Nellis Air Force Base in Las Vegas, Nevada.

The nature of joint ventures is such that problems will surface that require work to resolve. This applies to the Nellis Federal facility. It has encountered some problems which are being worked out. A recent trip by a high level team from the Air Force and VA has accelerated resolution of these issues. The team's excellent report and its recommendations, now being implemented by DOD, demonstrates the ability of the two departments to work together in effectively fixing problems.

With regard to the future joint ventures, specifically looking towards the Elmendorf joint venture in Alaska, DOD is firmly committed to working out the details in advance to assure that we don't have similar problems in the future.

Another area addresses Veterans Affairs Medical Centers as providers under both managed care support contractor arrangements, as well as in providing specialized care, such as head trauma and rehabilitative care. Approximately a year and a half ago, a CHAMPUS provider model was implemented at the VA Medical Center in Asheville, NC and this time, similar models are being implemented in Indianapolis and Syracuse, NY, where Griffiss Air Force Base, Rome, NY, is being closed.

No more of these are planned because of the on-going change in our system. The Department of Defense is continuing to implement its 12 region TRICARE program where a lead agent in each region is primarily responsible for health care delivery, and a managed care support contractor is at risk for delivery of CHAMPUS beneficiary care within the region. This is a support contract, as I think you're all aware. The two departments have now signed a memorandum of understanding enabling Veterans Affairs Medical Centers that wish to be TRICARE network providers, to do so if they meet the contractor's cost access and quality criteria. Those facilities that become providers provide another option for DOD beneficiaries. They would function in the same fashion as private sector providers and the beneficiaries' costs would be the same as when they use a private sector provider. This new effort will be phased in with the 2-year contracting schedule.

As I think you're aware, we intend to stand up the whole TRICARE system before the end of 1997.

In closing, Mr. Chairman, the Department of Defense will continue to work closely with the Department of Veterans Affairs to pursue sharing opportunities to save Federal dollars, provide qual-

ity health care, and still be able to respond to the demands of its readiness mission.

Thank you very much.

[The prepared statement of General Anderson appears on p. 74.]

Mr. HUTCHINSON. Thank you, General Anderson. I'll ask the question that is so basic. There's a lot of us here who are new and could either of you give us a picture of how the TRICARE model would work in a given situation?

General ANDERSON. Mr. Chairman, in this last bit of verbiage in my testimony, I attempted to explain that we have placed the Veterans Affairs hospitals in a situation of qualifying as providers under the TRICARE contract support side of the equation. The way TRICARE is organized, these is the direct care system, in other words, the Department of Defense Hospitals. We try to optimize around that system in terms of using everything that we have in the Department of Defense to provide care for our enrolled beneficiaries under TRICARE.

In areas where we cannot meet that full demand in the direct care system, we have a support contractor that fills in from the private sector to do that. What we are doing in this new scheme with TRICARE is including the Veterans Affairs Hospitals and Medical Centers in that side of the equation, along with the TRICARE support contractors.

The difference here for the beneficiaries has to do with the payment schemes on that side of the equation in the TRICARE support contractor network, if you will.

TRICARE prime, specifically the enrollment, the enrollment part of TRICARE (which is a triple option), is health maintenance organization-like. We are enrolling beneficiaries in this plan. They also have an option of going to a preferred provider network or using CHAMPUS as it is currently configured, so it's really a triple option.

What I've tried to do here is basically give you a feel for what we're aiming at as we stand this up by 1997.

Mr. HUTCHINSON. Now any VA hospital could apply and if they met the criteria, could be accepted in to the TRICARE program?

General ANDERSON. Absolutely.

Mr. HUTCHINSON. Now, could CHAMPUS beneficiaries then utilize the VA hospital?

General ANDERSON. Yes.

Mr. HUTCHINSON. Okay, and how many do we have participating in this now?

General ANDERSON. We have Regions 9, 10 and 12 (what was the CHAMPUS reform initiative in California and Hawaii) and that is a fully stood up system. We now have Region 11 which is centered around Madigan Army Medical Center in the Northwest, in the Seattle area standing up and we're enrolling thousands of people in the system. Certainly, we could, for the record, give you the update numbers, but they are ticking off right now. The system is starting up in an enrollment phase.

As I said, the region by region stand up of the program is coming over the next 2 years.

Mr. HUTCHINSON. In the TRICARE, are you finding that the cultural barriers or what we've talked about before on each department wanting to do their own thing, is that less of a problem?

General ANDERSON. Mr. Chairman, we don't really have the experience to answer that question as yet relative to Veterans Affairs. I think that's a fair statement, isn't it, Dr. Kizer? We only have the sharing agreements. We have the experience in Albuquerque which is very good at this point, but that's not under the TRICARE model. So if we're talking about the TRICARE model, we still need future experience to see how that's going to work.

Dr. KIZER. I would add that from the VA's perspective, we're raring to go. The VA facility managers are very enthusiastic and would love to participate in this. To some extent, we're limited by having to implement appropriate billing systems and other things already mentioned, which historically have not been part of the organization, but we are rapidly moving to do that. We're putting in cost accounting systems as our number one informatics priority. There is an agenda for that, and I think we have discussed that at some previous hearings. We're very enthusiastic about moving forward. I really don't see any cultural problems impeding this. One of the limiting, or rate limiting steps, is how quickly TRICARE comes on in the various areas. As was noted this will occur over the next 2 or 3 years. Also, I would note that we are within a matter of weeks of finalizing the agreement with the contractor for one of the TRICARE regions in the Texas area, that we're going to be able to do.

Mr. HUTCHINSON. Under the VISN structure is it the local hospital administrator that will make the inquirer request to participate? Do we have a lot of hospitals that are expressing interest to get into this?

Dr. KIZER. We have a lot of facilities that would be very interested in participating. One of the reasons is, of course, that we allow them to retain the funds so they can go back and improve services to our patients. Whether it's a VISN director or the hospital director that initiates things, I cannot say at this time. I expect it will probably be both as we move forward in developing the strategic plans for each of the VISNS. They're both going to be working on it.

Mr. HUTCHINSON. Now the administrative, I guess there are administrative barriers, the billing problems and the changes that you're making, how quickly are those going to be implemented? I mean how fast will we see an expansion in the TRICARE?

Dr. KIZER. Well, of course, the first and most important rate limiting step is how fast TRICARE comes on and how fast they get their contractors in place to then implement the program because we have to work through those entities.

As far as the VA system, the situation is variable. Some of our facilities are further along than others, as far as putting in place the billing systems, cost accounting systems, etc. You will hear testimony in a little bit I think, from some of our facility directors who can provide you a first-hand account of their experience in this regard.

I expect that as TRICARE providers come on line, our facilities will be ready, and we'll be part of the game.

General ANDERSON. Mr. Chairman, to get back to your cultural barrier, a comment or question, I would like to echo what Dr. Kizer has said and with a specific example. We did have a good deal of administrative barrier in the Asheville arena when that interaction occurred, but regarding the barriers, those were absolutely ironed out with enthusiasm on both sides. This is really the model for getting at the details of things like the billing procedures and so on. So, what we have experienced from the DOD side is a very enthusiastic approach to difficulties in breaking down the barriers very quickly, you know, weeks and months, not years.

Mr. HUTCHINSON. Thank you. Chet.

Mr. EDWARDS. General Anderson, I'd like to ask for your comment about the joint VA/DOD report of September 1 of this year. As a result of the study team that had looked at the Nellis situation, a report was issued, entitled "Financial Disincentives" and this is a direct statement from it. It says, "DOD budgeting at the national level anticipates VA revenue from deviate DOD sharing arrangements and offsets local budgets by the amount generated locally through these arrangements. Hence, local management derives no financial benefit from the sharing agreements."

Is that a correct statement or do you disagree with that statement?

General ANDERSON. I will not challenge the findings of that report at all. There are two things to think through though as you address this issue. One of them is the comment that Mr. Baine made before relative to the General Counsel and military pay. I assure you though that the Air Force itself who actually manages the budget, the Defense Health Program budget, that goes to Nellis Hospital is addressing that. You'll note that one of the parties of that report was the Surgeon General of the Air Force and what they are doing in response to the report is, of course, addressing each of the findings and the recommendations of the report. Clearly, the Surgeon General of the Air Force has some flexibility in the way he oversees the budget distributions to that hospital. My belief is that this is in the hands of the Air Force and the Surgeon General of the Air Force is authority level to look at how the distribution of funds are made and to enhance the incentives accordingly. So to again very firmly say that, we stand behind what was reported in that report and those recommendations are being addressed by the Air Force on the Department of Defense side.

Mr. EDWARDS. Sir, are you saying that the Department of Defense recognizes that it is not a correct interpretation of the law passed in 1982 to take away estimated revenues coming from the VA? Is that what you're saying?

General ANDERSON. Yes.

Mr. EDWARDS. Let me be more specific. The law says very directly, "any funds received through such a reimbursement shall be credited to funds that have been allocated to a facility that provided the care or services."

The analogy I would use would be if an employer by the law is required to pay an employee time and a half overtime. The employer says if you want to be aggressive and take initiative, Mr. Employee, work extra hours every week because every week I'll pay you time and half. The only problem is I'm going to dock you the

same amount of money from your regular paycheck. It seems to me that would be circumventing the Federal law.

Is it your opinion that the law is very clear and that it is not a correct and proper interpretation of it to be taking a dollar here for every dollar that comes in there?

General ANDERSON. It is my personal opinion and the position of the Department of Defense that the law is very clear relative to the fiscal incentives intended and that is being worked out according to what was found in this report. The action agency to do that is the Surgeon General of the Air Force and that is in their hands right now to do that.

I say that with the reservation relative to the comment that Mr. Baine made about the General Counsel and military pay lines and there are some accounting things that need to be looked at along that line and that is being accomplished also. That really is the extent of the comments that I can make. The answer to your question, yes sir, we recognize it.

Mr. EDWARDS. How long do you think it should take, General, to change the operating procedures and the financial incentives?

General ANDERSON. Weeks and months, yes sir.

Mr. EDWARDS. Thank you very much.

Mr. HUTCHINSON. Mr. Ney.

Mr. NEY. Thank you, Mr. Chairman. I had a question of Dr. Kizer. I think your testimony has a word of caution in it which is appropriate whenever you try to merge and on a state level in the past I've merged agencies and been involved in that type of process. You say in here on page 2 "if the involved parties are correctly motivated." I wanted to ask you how do you determine what type of problems are out there that have to be worked out? Do they go on to a list and the entities sit down? How does that work, the actual problems of merging. Are there technological or logistical or cultural—how is that put together? Do you get 1 through 10, are the problems that you have to work out?

Dr. KIZER. I think you're asking, if I understand it correctly, how do you determine potential problems when you merge entities, as for example, we began to do earlier this year with the merger of 17 of our hospitals under 8 management structures. Well, you look at the entities, determine what their mission is, and decide how you want to operate the merged facility. You basically make your list and say this is how we're going to address the new facility.

Mr. NEY. I know specifically you've got VA and DOD. When there's disagreements that happen, do those disagreements, maybe one is coming from VA and maybe one is coming from DOD, do they go on to some kind of list and there's a body that sits down and says here's five points that we have to work out? Does that happen?

Dr. KIZER. Ideally, that's what should happen, yes. You should have a mechanism designed into the process that will be the dispute resolution process. This should be designed up front because there absolutely will be disputes, and they're going to have to be resolved.

In the case of Nellis, one of the problems that surfaced was that there was not an effective mechanism for resolving disputes. Prob-

lems were surfaced or identified, and they languished. They basically didn't get dealt with. That, I believe is being addressed.

Mr. NEY. As this process goes through now, do we have something that will do that?

Dr. KIZER. Each facility, and I think that's what the General was saying except for the case of Elmendorf which is still on the drawing boards, that would be something that would be placed into it. Part of what was discussed there was how do we resolve those problems, how do we surface the problems, how do we then resolve them as well. There has to be a mechanism to do that going into it, otherwise, it will continue to generate problems, and we basically won't get them solved.

Mr. NEY. That's what I'm wondering. As far as the mechanism and I'd ask the question of you and the General, the bottom line of this and I think this has started out and proceeded well. I think it's a great idea, but the bottom line of it when you head into some of those head butting situations where there's a difference over here and a difference over here, who do you think in the end of it, who cuts bait? Who steps in to say you say one thing, you say another, who steps in, and I would like both of you to answer, to say who cuts bait?

Dr. KIZER. That actually goes to the point that I was making. If we're in the health care business, and the mission or the joint venture is health care, then in my judgment the person with the most experience in the business of health care should be the entity that ultimately should be in charge. If you're in the law enforcement business or the fire protection business or whatever it is, then you would go back to whoever has the most expertise in that regard, in my judgment.

General ANDERSON. You will hear some subsequent testimony here, I think, in the panels that follow from Alaska, particularly, but obviously when we have a problem in one joint venture such as we had at Nellis, we then look at what's on the horizon and clearly Elmendorf, the Alaska federal health picture is very important to us right now. There is a plan. There is a regular set of meetings that go on in Alaska to look ahead to exactly these difficulties with the idea that we will lay in place a process by which problems can be resolved at that level. If they can't, we are in direct contact here in Washington through Dr. Kizer's office and Dr. Joseph's office here. In the case of Alaska, that being an Air Force facility, the Air Force Surgeon General also gets involved in those things. So there are authority levels for resolution and we keep very close tabs on what's going on up there, as a specific example.

Mr. NEY. Thank you. I have one final question and I know the yellow light is on, General, in your testimony the beneficiaries who want the option can go to a VA medical center as long as it meets the requirements of TRICARE and its managed care contractors. That would be a private sector managed care component, I assume.

General ANDERSON. Yes.

Mr. NEY. So they have to basically approve the VA medical centers?

General ANDERSON. Yes.

Mr. NEY. Is there any structures in the VA that looks at DOD and approves it or something of that nature?

General ANDERSON. Let me address that in this way. We also hold the DOD facilities to exactly the same standards in this system. Now understand, we are operating from the DOD, the TRICARE system and this question has been one that we've talked over time and time again with the Veterans Affairs. I could understand some sensitivity here, but we really are all trying to meet the same standards, the same very high standards of quality of care in particular, and access to care.

Mr. NEY. If nobody objects, can I have 30 seconds?

Mr. HUTCHINSON. No objection.

Mr. NEY. Let me make a point here and I'm not saying who is right or wrong, better, etc. It brings out a good point if the VA doesn't have managed care if you have a managed care component that the VA agrees yes, it can look at us, why doesn't that managed care component basically certify the VA systems? Why have two systems? Because what starts to come to my mind, again, DOD has something that looks over VA to approve it, but what is coming from VA's end? I'm not criticizing anybody, but I'm just saying maybe we ought to have this existing system and make it to blend so that again we're breaking down barriers and there's a managed care component for everybody.

General ANDERSON. I understand very well the issue you're after. A practical answer to this is that we're handling this as 12 regions and they are under regional contract authorities with different contractors providing these services. The decision was made to put the VA in this system on the contractor side of the system, not on the direct care side. So having made that management decision, then you do get into this local phenomena of regionalization of the system.

Mr. HUTCHINSON. Mr. Bishop.

Mr. BISHOP. Thank you very much. Let me again echo my support for the concept of DOD-VA sharing. I think it's an excellent concept for the delivery of health. I've listened and maybe I'm not entirely enlightened on it, but I wanted to ask the questions now with regard to the utilization of VA facilities for DOD personnel which would come under the TRICARE system which seems to be pretty much rolling along. My question comes for the frequency of the proposed utilization of DOD facilities for non-DOD vets, particularly in areas where veterans don't have access to VA hospitals. I note that you are consolidating in the VA a number of hospitals for efficiency and for necessary budget cuttings and I understand that, but there have been even prior to the consolidation era areas that were undeserved in terms of access to veterans and there have been, for example, in some areas DOD facilities that veterans wanted to use or could use, but were prohibited from using, stopped from using as a result of case load or DOD regulations, or what have you.

So what I would like to know is whether or not it's going to be a two-way street? Can veterans who would normally be eligible under the VA system, not necessarily under the DOD as in retired military personnel, would they be able to go to DOD facilities, for example, Martin Army Community Hospital at Fort Benning, rather than having to travel to Tuskegee or to go to Atlanta or to go to Dublin to some VA facility?

Dr. KIZER. My understanding of the issue, and this really is DOD's issue, is that Veterans would not be eligible for care at active duty military treatment facilities.

General ANDERSON. Veterans are, in general, not beneficiaries of the DOD system. That's a matter of law. However, we do have the joint ventures and a number of these sharing arrangements where there is a possibility for mutual arrangements.

In terms of a system-wide beneficiary issue though, the veteran is simply not a legal beneficiary of the DOD system.

Mr. BISHOP. I guess I'm following up on Mr. Ney's suggestion where he was talking about the possibility of blending the two together. It seems to me that if we're talking about efficiencies and we're talking about the more effective delivery of service, if you have a DOD facility that's accessible to veterans, they ought to be able to use that subject, of course, to their own limitations, without having to travel hundreds of miles to some VA facility in the same way that you're going to allow DOD personnel to utilize VA facilities.

Dr. KIZER. I understand the issue, sir. We do not have, to my knowledge, any pending direction to change things in this area. I would point out—

Mr. BISHOP. That would require a change in the law? Would that be subject to again a memorandum of understanding or some contractual agreement between DOD and VA?

Dr. KIZER. If I understand your thrust here, sir, that veterans, in general, would be beneficiaries of the DOD system, this would require changing the law. We have worked out a number of individual location sharing agreements based on work load. Where we can make the sharing concept mutually beneficial, that has worked. For example, Tripler Medical Center in Hawaii has for years treated veterans in that facility, and they are pressing on as one of our eight locations for continuation along that line.

Mr. BISHOP. I guess could VA contract with DOD, for example, to provide those services for veterans in an affected area where there is a DOD facility and there are veterans in need of utilization of the facility?

Do you have authority to do that now if you wanted, if VA were to offer to suggest, to convince you to enter into a contract, would you have the authority?

Dr. KIZER. I believe we could work out a department level arrangement to do something like that. I don't see an individual location where that would really apply right now, because of the lack of excess DOD capacity in the current downsizing environment. We've already closed 42 percent of our beds in DOD.

Mr. BISHOP. The final question then has to do with additional construction. Is there any way that budgetarily VA and DOD can have joint constructions in a DOD facility, for example, to add additional capacity so that there will be access for veterans who are in a particular area to ease the availability of services for them, for their convenience?

General ANDERSON. Yes sir. That's exactly what we're doing in Elmendorf. In the Elmendorf case, for example, and what we did at Nellis, in fact, was to plan from the beginning to build the hospital that would serve both needs.

Mr. HUTCHINSON. Thank you, Mr. Bishop. Mr. Clements is occupied. Before I dismiss the panel I just want to say I think there's been some interesting issues raised, but I know that there are lots of folks and I get contacted by them frequently who are CHAMPUS beneficiaries who live near a VA hospital. The hospital there who would love to have access to be able to utilize that VA hospital rather than traveling sometimes many hours or hundreds of miles to the nearest DOD facility. So I hope that there's a great promise in what we'll see in future years in the TRICARE model. I get contacted a lot by other Members who have VA hospitals in their districts and who are curious about what they can do to develop these sharing agreements, these joint ventures or to get into TRICARE. Does the Panel, Dr. Kizer, General Anderson, have any advice on what direction we can point them?

Dr. KIZER. Well, sir, I would, since you asked, make a pitch for some of the provisions that are in the reconciliation bill that would expand our sharing authority. Certainly, as we look to the future and the new operational and managerial paradigm that we hope to operate under in the future, we need to have essentially unlimited ability to contract with other entities and to enter into sharing arrangements or joint ventures with private providers, with our university affiliates, with DOD, and with other Government agencies. We would very much like to have, and we feel that we need, indeed desperately need that, if we're going to provide the service we want to provide to our veterans and to really make it work and be rational. Of course, if we could address some of those eligibility rules and statutes that are so much in need of change, that would provide us a system and the vehicle to provide the service that our veterans deserve.

Mr. HUTCHINSON. Good. Could you help educate CBO as to the benefits of eligibility reform?

Dr. KIZER. Actually, if it would be helpful I have a formula here for CBO. If the Congressional Budget Office would just plug in the numbers, they would see that our eligibility reform proposal is budget neutral. Going back to the comment that was made here, we are absolutely convinced that we can substantially increase our accessibility, improve our accessibility, site dozens and dozens of access points in community-based clinics; if we could amend those silly eligibility rules, we could make the system work a whole hell of a lot better.

Mr. HUTCHINSON. All right. And all of this eligibility reform as well as the joint ventures sharing agreements, TRICARE, all of that is not primarily budgetary-driven, but better service and accessibility to veterans.

General ANDERSON. Yes, Mr. Chairman, we, of course, in the Department of Defense do focus primarily on readiness, medical readiness is our theme. We do operate, though, as you know, a comprehensive system of health care for our beneficiary population. Many of them are also veterans, by the way.

We hear a lot from CHAMPUS-eligible beneficiaries and others as well. I assure you, Dr. Joseph and his staff are well aware of the things that you hear. Of course, one of our biggest problems in standing up TRICARE is our difficulty to deal with the older than 65 Medicare-eligible population who are otherwise potential bene-

ficiaries to TRICARE. We would like to, of course, enroll everyone in TRICARE for life, essentially, so I would also ask that you address your attention to Medicare issues. That's a really big one for us and does overlap with other concerns of people that you worry about. So again, I appreciate very much the opportunity to come and talk with you today about these joint ventures. We are really enthusiastic about TRICARE and about the opportunities that that will offer the Department of Defense and the Department of Veterans Affairs as we expand our horizons in providing quality health care.

Mr. HUTCHINSON. Mr. Clement, did you have any questions for the Panel?

Chet, anybody else on the Committee? I thank you for your testimony and we'll dismiss you.

Dr. KIZER. Thank you.

Mr. HUTCHINSON. Panel 3, if they would please come to the table. It consists of Mr. Al Poteet, Director of the Anchorage, AK VA Outpatient Clinic and Regional Office; Mr. James A Christian, the Director of the Asheville VAMC; Mr. Alan Harper, the Director of the Dallas VA Medical Center; and Mr. Michael Harwell, the Director of the Central Texas Medical Centers, headquartered at Temple, TX. We welcome you. Thank you for being here today. Mr. Poteet, we will recognize you, if you would like to begin.

STATEMENTS OF AL POTEET, DIRECTOR, VA MEDICAL AND REGIONAL OFFICE CENTER, ANCHORAGE, AK; ALAN G. HARPER, DIRECTOR, VAMC DALLAS, TX; JAMES A. CHRISTIAN, FACHE, DIRECTOR, VAMC ASHEVILLE, NC; AND R. MICHAEL HARWELL, DIRECTOR, CENTRAL TEXAS MEDICAL CENTERS, TEMPLE, TX

STATEMENT OF AL POTEET

Mr. POTEET. Thank you, Mr. Chairman. I'd like to summarize my statement very quickly with the understanding that the full text will be included in the record.

Mr. HUTCHINSON. Without objection.

Mr. POTEET. I have and will continue to be a big supporter of the concept of the VA/DOD sharing and joint venturing. Specifically, in Alaska, we will continue as federal partners to aggressively put together these win-win relationships between VA and DOD. It's imperative that we do this because of the extremely high cost of providing quality health care which often exceeds 200 percent the costs in the lower 48. Sharing agreements, by the way, have been a way of life in Alaska. Our first sharing agreement to provide Air Force health care to veterans precedes Alaska becoming a State.

VA Medical Center in Anchorage is the only VA health care provider in the State and currently we have sharing agreements with Bassett Army Hospital in Fairbanks, Third Medical Group in Elmendorf and we're also signatories to the Alaska Federal Health Care Partnership which was signed by the Indian Health Service, Coast Guard, Army Medical activity in Alaska and the Air Force.

This partnership is a blueprint for the joint cooperative and sharing throughout the State and has already saved substantial amounts of money. In fiscal year 1995 the VA spent \$1 million with

the Third Medical Group. The same medical care in the private sector would have exceed \$1.8 million. Sharing of this excess capacity will continue to be a successful part of our future in Alaska.

Just as a way of an example, in Fairbanks, when we have an orthoscopic surgery performed on a knee, it can cost up to \$8,500 in the private sector. When we pay for the veteran to come down Elmendorf, have the surgery, and return at the taxpayers' expense, VA pays about \$900, and thereby we get to take care of nine additional veterans. These are the kinds of relationships we want to continue building on because they're extremely cost effective and we provide quality care.

As far as joint ventures are concerned, the VA and the Air Force in Alaska clearly have different missions and cultures. Basically, the Air Force is involved in readiness and we, of course, are there to provide health care through 365 days a year to our entitled veterans. Obviously, these differences can have a serious impact on joint venturing.

The Third Medical Group in Elmendorf is not a full service, tertiary care medical center, nor will it be upon the completion of the Air Force replacement hospital in late 1998. I think this is a factor that may diminish our potential for success. We understand, up front, that the Air Force mission of readiness is to be prepared and take care of shooters in a time of war. This by its very nature does not presume an on-going relationship between VA and the Air Force at Elmendorf during a movement from a peacetime to wartime scenario. The Air Force as the host at Elmendorf also poses a bit of a dilemma for the VA. In my opinion, the host facility must provide as its primary on-going mission, health care geared to the highest acuity of patients and 365 days a year during wartime or peacetime. Since the Third Medical Group will be our host, establishing a true joint venture, one that is workable and realistic, will be difficult. This is especially true in the arena of uncertain budgets when neither the VA nor the Air Force may have the resources to plan on in the future.

Having said that, I'd like to also note that we in the VA and my counterparts in the Air Force have a very close working relationship. We do propose to work very diligently and as much as practicable to have a joint venture that will take care of the needs of the Air Force and the VA in Alaska.

That concludes my comments.

[The prepared statement of Mr. Poteet appears on p. 85.]

STATEMENT OF JAMES A. CHRISTIAN

Mr. CHRISTIAN. Thank you, Mr. Chairman. I appreciate the opportunity to appear before you and the other members of the subcommittee and discuss the issues of VA and DOD sharing. I currently serve as Director of a 275-bed VA Medical Center with 120-bed nursing home. Last year, we treated about 6,000 patients, inpatients; and about 90,000 outpatients. Our hospital is affiliated with Duke University and we provide all levels of care, including heart surgery. Our veterans come to us from western North Carolina, Tennessee, Virginia and upstate South Carolina and our service area includes over 100,000 veterans. It's particularly important for you to know that a large number of military retirees are located

in this region and yet there is no direct military health care facility nearby.

Many of these military retirees had expressed frustration in their ability to obtain health care at our VA Medical Center in Asheville. Many of them are non-service connected and are above the means test eligibility. In 1992, I appeared before this committee expressing our desire to serve these veterans in a sharing agreement with the Department of Defense. In the fall of 1992, you authorized the VA to establish some pilots to allow CHAMPUS eligibles to be served by VA medical centers on a space available basis. Our hospital was selected for such a pilot and it began in March of 1994.

We have now one year's experience with that pilot and I would like to tell you about our experiences. First, and most important, no veteran has been restricted from access to care because of this pilot. We set up a primary care clinic for CHAMPUS patients and currently have 780 beneficiaries enrolled in this clinic. The staffing is supported from revenue received from DOD, other insurance sources and patient payments. Where we have specialty clinics that are filled, we refer the CHAMPUS patients to our local private sector providers, however, the primary care clinic provides the full range of services to CHAMPUS beneficiaries including diagnosis evaluations, screening tests such as Pap smears, care for short-term illnesses, as well as maintenance for the therapy for chronic diseases. The clinic is staffed by a physician, a physician's assistant and a registered nurse who sees patients 2 full days and 3 half days per week. The clinical team is able to treat 18 new patients and 49 established patients each week. We have found there are numerous opportunities to provide services to this population of patients. We currently have over 1,630 CHAMPUS beneficiaries who are registered in our CHAMPUS program, with an average number of 66 new registrants each month. Many of these beneficiaries continue to receive their care from private sector providers, but choose to have their prescriptions filled and obtain diagnostic studies such as x-ray and laboratory tests at the VA medical center.

Inpatient treatment is also available to CHAMPUS beneficiaries. Since the program's implementation we have admitted 55 patients for a variety of problems including cancer care, acute pulmonary disease and gynecological disorders.

Under this pilot we have agreed to accept a discounted CHAMPUS reimbursement rate which affords cost savings to DOD. CHAMPUS beneficiaries also benefit by the agreement because their cost shares are based on a percentage, lower percentage at the discounted rate. We have received in excess of \$482,000 in revenue from insurance payments and beneficiary cost shares and co-payments. Although we experienced administrative and clinical growing pains, which are inherent in any new endeavor, we have reached a point in this program where the efficiency of our operations has increased and we are realizing a return on our investment in the form of revenues in the excess of our costs. The ways in which this revenue can be used to benefit our veteran population is currently being evaluated.

Because of this pilot, Asheville has been invited to meet bi-monthly with Region 2 DOD Hospital Commanders. At that network level, we have developed a memorandum of understanding

that promotes sharing within our hospitals and sets forth guidance for expanded relationships. We see a real opportunity to continue to work together to better serve both of our beneficiaries. For example, we have a proposed clinic to be established in Charlotte where there are no VA facilities. DOD and VA have no facilities in Charlotte, and they have no managed care contract at this time. Why not jointly establish a solicitation to local providers to provide care for VA and DOD beneficiaries in that area?

The VA's primary mission is health care. We recognize DOD's primary mission is providing for the defense of the country, not health care. Health care for retirees and dependents is but a very small part of DOD's operational activities. Although we both have the same objective to provide care to those for whom we are responsible, we seem to be working at cross purposes in this endeavor.

In consideration of this, we would like to note some of the major barriers to expand and share between VA and DOD facilities. First, FTE restrictions limit our expansion of internal VA resources, even though funds come from DOD. The various uniformed services control DOD CHAMPUS funds, but there is no uniformity for VA to be reimbursed by a DOD medical facility, for instance, Army, Navy, Air Force. They all kind of have their different controls and rules. Many barriers to VA sharing at the field level are caused by the apparent problems of the DOD services and health affairs and transferring CHAMPUS dollars to the VA. DOD insists billing for services must go through fiscal intermediaries, much like our Asheville pilot. DOD health affairs is reluctant to move to large scale implementation of pilots similar to our Asheville model. If the region lead agents could control the CHAMPUS funds for all of the services in the entire region, sharing would be greatly facilitated.

Finally, there appears to be at the DOD level a reluctance to expand sharing programs. This may be due to the institution of the contractor-oriented TRICARE program, but the 172 VA hospitals in their strategic locations throughout the country should not be discounted. Most commanders and VA Medical Center Directors are ready to share sites and facilities, but the programs will never happen effectively, unless there is an efficient way to transfer resources, particularly in the CHAMPUS area.

I appreciate the opportunity to provide remarks and we'd be happy to answer your questions, Mr. Chairman.

[The prepared statement of Mr. Christian appears on p. 94.]

Mr. HUTCHINSON. Thank you, Mr. Christian. Mr. Harper.

STATEMENT OF ALAN G. HARPER

Mr. HARPER. Thank you, Mr. Chairman, members of the subcommittee. I am pleased to have the opportunity to discuss the Dallas Department of Veterans Affairs Medical Centers' participation in TRICARE. This joint venture represents a significant opportunity to build upon and complement our existing sharing initiatives with DOD. Currently, we are working in close cooperation with Foundation Health Corporation as the DOD managed care contractor. In this process, we have enjoyed the support of VA Headquarters, DOD Health Affairs and Foundation Health as we prepare for network participation in November 1995.

As an alternative choice, DOD's TRICARE beneficiaries, the Dallas VA Medical Center and our Fort Worth satellite outpatient clinic will provide accessible high quality and cost-effective care, consistent with DOD criteria and community standards. Our participation as a TRICARE provider highlights the natural relationship between VA and DOD beneficiaries which share the common bond of military service. It is also on this basis that we have received the unwavering support of both the Greater Dallas Veterans Council and the Tarrant County Veterans Council as we enter into this initiative.

Significant benefits are associated with our participation as a TRICARE provider. Of first and foremost importance is the opportunity for revenue generation. In these times of scarce resources, it is imperative that we have the ability to generate supplemental funding in support of enhancing veterans access to care. The revenue generated from our participation will be reinvested to expand health prevention and screening initiatives, community access to primary care and the overall scope and level of services available to veteran beneficiaries.

These advantages to our VA beneficiaries and improved access in cost effectiveness of care, to DOD provides a win-win situation for our two Federal agencies.

Secondarily, the more diverse array of medical conditions associated with TRICARE beneficiaries will expand the training experiences available through our graduate medical education, nursing and allied health training programs. The increasing incidence of high risk, multi-system disease in our veteran beneficiaries can be offset by a younger and healthier TRICARE population of relatively lower risk. Balancing patient risk is particularly important in managing outcomes in cardiac surgery, organ transplantation and other procedure based programs.

Job satisfaction and the recruitment and retention of highly qualified health care professionals will also be enhanced by the enriched clinical practice supported by this diverse case mix.

While our Medical Center currently treats women veterans and CHAMPVA VA beneficiaries, the anticipated influx of women beneficiaries under TRICARE would generate new economies in support of the development of additional in-house services on the basis of cost effectiveness.

As an overview to our participation as a TRICARE provider, we recognize the divergent health care missions of DOD and VA. To maximize DOD's primary role of defense and VA's basic mission of health care, efforts should be undertaken to capitalize on our respective strengths by classifying VA health care facilities as secondary priority providers, solely for the purposes of TRICARE participation.

Classification as a secondary priority provider is based upon cost incentives to DOD and would permit VA facilities to assume a more front line position and expanded role within the managed care contractors provider network. Under this concept, the contractor would be required to establish referral mechanisms to insure optimal utilization of VA as well as DOD MTF facilities and resources.

The DOD MTF would be contacted as first line providers followed by VA facilities as second line providers to determine capacity before referring TRICARE beneficiaries to civilian providers. Clearly, the issues and details associated with the concept of classifying VA health care facilities as secondary priority providers for the purposes of TRICARE participation require joint discussions between VA and DOD. However, the implications of this concept based on cost effectiveness, quality patient outcomes and advantages to VA and DOD's respective beneficiary population must be appreciated and underscored.

The Dallas VA Medical Center in our Fort Worth Outpatient clinic would welcome the opportunity to participate with the lead agent's office in DOD Region 6 in piloting this concept as a joint demonstration project.

That concludes my statement, Mr. Chairman, and I'd be pleased to answer any questions.

[The prepared statement of Mr. Harper appears on p. 92.]

Mr. HUTCHINSON. Thank you, Mr. Harper. Mr. Harwell.

STATEMENT OF R. MICHAEL HARWELL

Mr. HARWELL. Mr. Chairman and other subcommittee members and guests, I'm pleased to have this opportunity to discuss issues related to joint ventures and VA participation in TRICARE.

I sincerely appreciate your interest in and the support of the Central Texas Medical Centers with facilities at Temple, Waco, Marlin and Austin, TX. As the former Director of the Albuquerque Medical Center, I was in charge of an affiliated tertiary care center with a wide variety of programs and services. Due to our joint venture with the Kirtland Air Force Base Hospital, I was able to enter into numerous sharing agreements that benefitted both veterans and the Department of Defense beneficiaries. In fiscal year 1995 the Albuquerque Medical Center was reimbursed by DOD for approximately 400 inpatient stays and approximately 7,000 specially outpatient care visits. Revenues generated from these patients were used to enhance a number of different programs for the VA such as the Women's Health Program and expand our cardiology program at Albuquerque.

Since my arrival at the Central Texas Medical Center, I met with the Commander or Command Structure of Darnall Army Community Hospital at Fort Hood, TX, to discuss the possible DOD-VA sharing. We recently initiated a sharing agreement that allows for Army soldiers to receive a compensation and pension exams just prior to their discharge from the Army, with VA providers at Darnall Army Hospital.

We are also exploring the use of shared surgical space at the Temple facility whereby Army medical staff would perform surgical procedures for their beneficiaries in that space. The Commander of Darnall Community Hospital and I expect to enter into other areas of sharing in the future.

Earlier this week members of my staff met with Foundation Health Care staff to discuss the Central Texas Medical Center's participation in TRICARE. The Central Texas Medical Center was earlier reviewed by Foundation Health and received 100 percent compliance with the full delegation of credentialing and privilege re-

view and I fully expect to be in an active participatory role with TRICARE by the end of the, by the beginning of the calendar year.

I have provided a much more extensive summary of my written testimony and my written testimony and I would be pleased to answer any of your questions at this time.

Thank you.

[The prepared statement of Mr. Harwell appears on p. 97.]

Mr. HUTCHINSON. Thank you, Mr. Harwell. I thank the Panel. Mr. Harwell, you've been described as the most experienced VA Director within the system on joint ventures and sharing arrangements, so if you had to kind of sum up what is the key to the success and the secret to these kinds of arrangements, what would it be?

Mr. HARWELL. I think, I listened to Mr. Baine and what he said and one of the things I agree with very much, it takes a lot of time to make it run smoothly and he indicated that in the Albuquerque experience. I was there from 1990 through 1995, until February of 1995.

I think what you have to do is there has to be a need on both sides and there has to be a provision to meet that need on both sides. In other words, we have to understand their readiness mission. That's what they do. And we have to accommodate that. At Albuquerque, we made use of that by when they had their readiness exercises, we participated to meet our joint commission accreditation standards for our emergency exercises. On the other hand, when they had to leave for certain things, we took over some of their patient care responsibilities, so I think you have to accommodate each other on your strengths, not pick at the weaknesses. You have to recognize those and go into it as a partner. Why else would you need a partnership unless you could meet their needs in some way.

Mr. HUTCHINSON. Mr. Harper, it's my understanding that DOD has recently awarded a contract which covers Texas, Oklahoma, Arkansas and Louisiana. I'd like to know the status of that contract and who is the awardee and what role, if any, the VA will play under this arrangement, and particularly I'm interested in the impact upon smaller rural VA facilities like my district in Fayetteville, AR.

Mr. HARPER. Mr. Chairman, the contract was awarded to Foundation Health Corporation and they are in the process of putting together a health care network. They're supposed to come out in November with this plan that would cover all the CHAMPUS beneficiaries in those States that you identified.

VA has gotten involved in that we want to become a TRICARE providers. We have received excellent cooperation from Foundation Health. They too have visited our facility. They have reviewed our credentialing and privileging program, found it to be 100 percent in compliance with their requirements and granted us delegated credentialing and privileging authority. Foundation Health has a desire, and appropriately so, to develop a prototype contract that would be used by all VA medical centers. We've had excellent cooperation from our headquarters. Our sharing office and our General Counsel Office have reviewed the proposed prototype contract submitted by Foundation Health and have communicated changes

on two occasions. The prototype contract is back at Foundation Health now for their final approval. Once that's done, then we will sit down and get into more detailed discussions with Foundation Health about the services that we would provide.

We have agreed in our proposal that we would offer them a 25 percent discount on CHAMPUS maximum allowable charges and we haven't worked out all the details of billing and those kinds of things.

Where do the other VAs fit into this? As Mr. Harwell indicated, he has had discussions with Foundation Health as well and we as the pilot in Dallas are keeping them informed. I would see the Central Texas network facilities coming on-line about the same time as Dallas. It's up to each individual medical center to determine what role that they have with Foundation Health and the TRICARE program. It's something that I think that if they don't do, they're missing the boat. The thing that I alluded to in my opening remarks that I think is very important is the concept of a secondary priority provider. DOD has first shot at these people. I think the VA ought to have the second opportunity and not stand in line with the private sector facilities. Again, I reflect back to the scarce resources, the need for Federal agencies to work together and I just think that that makes a whole lot of sense from a taxpayers' perspective. We do have tremendous support from our veteran community to get involved in this program, so I think they would welcome as active a role as Congress would allow us to have as a TRICARE provider.

Mr. HUTCHINSON. So if the agreements are reached and your negotiations with—is it Foundation Health Corporation?

Mr. HARPER. Foundation Health Corporation.

Mr. HUTCHINSON. If that is consummated, then each VA medical center would have certain criteria that they would have to meet in order to participate. Is that correct?

Mr. HARPER. Yes. They would have to negotiate with Foundation Health and Foundation Health would want to look at their credentialing privileging program to make sure that it meets their standards. They would have to agree to certain costs agreements.

Mr. HUTCHINSON. So your negotiations with Foundation Health would only make possible the individual hospitals' agreements?

Mr. HARPER. We're basically going to be a prototype example that would be used in the future.

Mr. HUTCHINSON. Okay, so the impact on a CHAMPUS beneficiary that's in the region of a VA Hospital that wants to utilize that, what impact would they, if that hospital decided to participate and if Foundation Health agreed that they could be one of the providers, they then would?

Mr. HARPER. The CHAMPUS beneficiary would have the option to come to the VA or elect to go somewhere else for their health care. VA would be an option for them. Right now we're not an option for them.

Mr. HUTCHINSON. Would the costs be comparable if they went to—

Mr. HARPER. Well, the way it's set up now they would have to pay the same co-payments that they pay the private providers for their care. We'd like to see some incentive there for the beneficiary

to come to VA and again that's where we get into that secondary priority provider.

Mr. HUTCHINSON. Good, thank you. Mr. Edwards.

Mr. EDWARDS. Thank you, Mr. Chairman, first my thanks to all of you for being here and especially my appreciation to all of you for the service you're providing veterans and seeing that they receive quality health care. It's a terribly important responsibility.

On a personal note I want to say hello to Al who used to be in Central Texas and did a great job at the VA Regional Office there and Mike Harwell, one of my present constituents who's done a great job at trying to bring about efficiencies and coordinating efforts between several VA medical centers in Texas and welcome personally to both of you.

Mr. Christian, we had some witnesses earlier that suggested perhaps there's really no need for legislation in this area. There's cultural barriers that needed to be broken down, not legal ones, but I think some of your comments might be well taken. It seemed to me you were suggesting there really is a need for some legislation with possibly FTE restrictions being a problem. You talked about the efficient transfer of CHAMPUS resources. Could you talk a little bit more about two or three or four areas where you think it would be important to have legislation to encourage these cultural changes, what those areas would be?

Mr. CHRISTIAN. I appreciate both those issues and questions, Mr. Edwards, particularly in the FTE issues. In my local CHAMPUS clinic right now I would like to expand. As I mentioned, we're seeing about 66 new beneficiaries coming to us each month. We haven't even advertised this program. We're afraid to advertise it to all the 36,000 beneficiaries in our area for fear of being swamped. What we can't do is add staff to support that function because we have a FTE employment control level at our hospital, and that's true of all sharing programs, whether you're sharing laundry facilities or whatever. The FTE issue for VA medical centers is an issue.

In some areas where we have affiliated medical schools that are right across the street, we may be able to use some contract providers and so forth and develop that sort of relationship where it doesn't count against our Government-wide FTE head count. However, for total access and flexibility in this program and to mutually save money, we've set up some arbitrary controls on FTE controls Government-wide that really are dysfunctional and competes with the objective to save money.

In our CHAMPUS program alone and pharmacy, we're saving DOD 67 percent on each prescription from the retail price and we filled 19,000 scripts in the first year. That potentially can be a significant savings over the whole VA system as we work in such areas as pharmacy and other areas and yet, I can't add additional pharmacists because of my FTE controls.

The other area that particularly has been frustrating to me is how, and this is more an internal matter with DOD, but the CHAMPUS pot of money is controlled, at least from my perspective maybe I'm not fully educated, but I've been working on this since 1991, that the Army, Navy and Air Force basically have control over how they control those CHAMPUS funds within their uni-

formed services. And as General Anderson indicated the lead agent for each region now much like our VISN director, but different, the lead agent has been given sort of the coordinating responsibility of all this managed care responsibility, but in my view it's not clear to me that the lead agent has been charged with control of all those CHAMPUS funds. If the lead agent in the region had control of those funds, he could determine where and what VA medical center within that region we can work out the deals. Now, the Army is a little bit more flexible than the Navy, for instance, in terms of transferring CHAMPUS funds to a medical facility and using it for some sharing projects. The Navy, most of their money from what I understand is controlled right out of BuMed. I may be misinformed on some of this. I'm not sure this is legislative issues. It may be, but I think it may be more administrative within the Department of Defense and Health Affairs.

Mr. EDWARDS. Very good. I appreciate that. Very quickly, Mr. Harper, along the same lines of the question is legislation needed, would it require legislative action to change the co-payment arrangement on the VA and TRICARE or does DOD have that authority?

Mr. HARPER. I do think that requires legislation, but I'm no expert in that area. I think it does.

Mr. EDWARDS. Very good. One last question, Mike, to you. You talked about some of the things you're trying to do with Darnall Hospital at Fort Hood and the VA Center in Temple. Are there some examples of things you'd like to do that you cannot do because of either DOD constraints or cultural problems or legal problems? Any specific examples of areas where you think it would be in the interest of our veterans and military families to work together, but we need to help break down some of those barriers?

Mr. HARWELL. I haven't seen any yet, Congressman Edwards. We've only entered into negotiations. We've got two teams. One is from Darnall and one is from ours, right now in surgery sitting down making up a proposed plan. They're to have that to us within another couple of weeks. So they've been very cooperative and of course we have some excess capacity in the surgical arena. So we haven't seen that yet.

As you move through these, we very well might and I'll keep you informed if we do.

Mr. EDWARDS. Very good. Thank you.

Mr. HUTCHINSON. Mr. Bishop. Mr. Clement.

Mr. CLEMENT. Thank you, Mr. Chairman. It's great to have the panel here today. I think some of the questions may have been already answered to some degree, but I wanted an idea about how many active service members have you seen and I think from what your testimony has said is that you'd be overrun if you really advertised it to any degree. But what has been your experience so far and I think some of you have already responded to that?

Mr. CHRISTIAN. At Asheville, we're the only provider at this time, other than the joint venture at Albuquerque. In the CHAMPUS arena, about 47 percent of all of our beneficiaries that we have enrolled in our CHAMPUS are retired military veterans. The rest of it is mainly they're dependent, they're spouses and in a few cases some of their children. You know, we have about 1,620 already en-

rolled in the program, but many of them are just getting their pharmacy prescriptions filled at the VA. There's only about 780 that are in our CHAMPUS clinic, but again, without evening advertising, we're seeing 66 new applicants for the program every month and why are they coming to us? They feel like they're not having to pay us much for their pharmacy prescriptions under our model and that's a big issue for retired folks and the other issue is their co-payments and deductibles are less than the private sector because we have a discounted rate.

Mr. CLEMENT. That's one thing I was going to ask is about the quality of service, so most people are coming to you for the pharmacy more than anything else?

Mr. CHRISTIAN. Mr. Clement, those that are coming into the clinic though are extremely well satisfied. We did a survey and on a scale of five points the average was about 4.6 on all questions. The beneficiaries are very pleased with their status, their access, their timely access to our primary care clinic. To get a new clinic appointment, it takes about 6 weeks for them to get into this clinic.

Mr. CLEMENT. Well, you know we've had a number of our veterans complain about delays, but you don't feel like with this shared agreement, joint agreement that that's brought about more delay?

Mr. CHRISTIAN. Not for veterans because we basically set up this clinic separate and apart with DOD money, running really almost a self-contained program that doesn't deal with delays. Now where I have a delay of a referral to a specialty clinic, say like orthopedics where we have a three month backlog, the CHAMPUS beneficiary is sent to the private sector for that type of referral because the last thing I want to do is have a CHAMPUS beneficiary, non-veteran going ahead of a veteran who feels like he should be there first. That's our primary mission.

Some clinics and particularly in a specialty clinic, these CHAMPUS beneficiaries are being asked to go to the private sector. However, if I had the FTE restrictions lifted, I could hire an extra orthopedic surgeon and reduce my waiting time in orthopedics and at the same time improve care to our veterans and reduce their waiting time.

Mr. CLEMENT. Well I know we've had this authority for a while, but it seems like most places are moving very, very slowly in these shared or joint agreements. Is the region budgetary? Is that the primary reason more places are not moving towards these agreements or is it they don't have the knowledge of the agreements and how to put it together and they're not asking some of you that have already done it?

Mr. HARPER. I'd like to comment about that.

Mr. CLEMENT. Yes.

Mr. HARPER. I think we've got to be careful in making sure you understand which we're talking about. When we're talking about sharing agreements, there are a number of sharing agreements that we have with DOD doing lab tests and emergency treatments and all those kinds of things. There's an awful lot of those, but there's very limited involvement in the CHAMPUS and some of the joint venture things, more elaborate, I guess, kinds of agreements. But we have an awful lot of sharing agreements with DOD for a

lot of little things, but there's a lot of sharing going on between VA and DOD.

Mr. CLEMENT. Okay. I know you've already mentioned one recommendation for us to consider for the future. Any other recommendations the rest of you might have?

Mr. POTEET. There might be something to the notion and the efficacy of having some sort of a jointly staffed entity between DOD and VA where some of these problems as far as joint ventures can be resolved because to do the long range planning, for example, at Elmendorf in a parochial way that the VA and the Air Force has to do, it's very difficult to do that when your methodology of determining resources is at best a wet finger in the air and we don't have any assurances that we're going to have resources to do the kinds of things that we ought to be doing in order to take care of the DOD and the VA beneficiaries, so there might be some efficacy in having that kind of arrangement where the emphasis would be put on what is happening not to micromanagers in the field, hopefully, but to assist us in bringing these issues to the attention of both departments.

Mr. CLEMENT. Mr. Harper, Mr. Harwell.

Mr. HARWELL. I'd like to just amplify a little bit and back up what Alan said in his formal testimony. The situation at Albuquerque, you asked for numbers and they did not have a CHAMPUS arrangement, but they had what they called an alternative method of care which means that the MTF at Kirtland had the money and they could use the VA as he said as a preferred provider in lieu of CHAMPUS, but it worked the same way, except the MTF could control the money and we took care of about 11,000 active duty and dependents through that system, mainly in specialty clinics and inpatient stays for subspecialty care. It worked very well. It wasn't classified as a CHAMPUS initiative in those days, but it worked the same way in that they gave the MTF money and they purchased that from the VA or the preferred provider rather than what they call releasing them to CHAMPUS. So I'd like to say that that's a good idea, I think, in my opinion, me personally. I think that's a good idea to look at.

Mr. CLEMENT. Thank you very much.

Mr. HUTCHINSON. Thank you, Bob. We have a vote so I'm going to excuse this panel and thank you for your participation and we'll stand in recess for about 15 minutes and reconvene for the fourth and final panel of the day. Thank you very much.

(Off the record.)

Mr. SMITH of New Jersey (presiding). The subcommittee will come to order. Chairman Hutchinson was called away and will not return, but I'd like to ask the fourth panel if they could present their testimony and this panel consists of Larry Rhea, the Deputy Director of Legislative Affairs for the Non Commissioned Officers Association; John Vitikacs, Assistant Director of National Veterans Affairs and Rehabilitation Commission at the American Legion; Robert Carbonneau, National Director of the AMVETS; and, Bob Manhan, Assistant Director of the National Legislative Service of the Veterans of Foreign Wars. Who would like to go first, Mr. Rhea.

STATEMENTS OF LARRY D. RHEA, DEPUTY DIRECTOR OF LEGISLATIVE AFFAIRS, NON COMMISSIONED OFFICERS ASSOCIATION; JOHN VITIKACS, ASSISTANT DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION; ROBERT P. CARBONNEAU, NATIONAL LEGISLATIVE DIRECTOR, AMVETS; AND, BOB MANHAN, ASSISTANT DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS

STATEMENT OF LARRY D. RHEA

Mr. RHEA. Thank you, Mr. Chairman. The Non Commissioned Officers Association is very appreciative of the invitation to testify this morning and although Mr. Hutchinson is not here at the moment, we certainly would like to commend him for the very hard work that he has done on Veteran Health Care issues during this session of Congress, whether it's eligibility reform or some other difficult issue.

Mr. Hutchinson, the chairman of the subcommittee, has not hesitated to take on some rather tough issues. And he has been more than forthcoming and generous in the time that he has devoted to veteran organizations and I'd be remiss if I didn't start my oral comments by expressing my appreciation to the chairman of the subcommittee. So we thank him for that and we thank you for including our statement in the hearing record.

As we indicated in our prepared statement, Mr. Chairman, the NCOA fully supports and we have and we will continue to fully support the sharing agreements and the joint venturing between DOD and DVA, but for our testimony today, we chose to address only one aspect of this huge issue and that's in relation to the June 29, 1995 memorandum of understanding relating to TRICARE and VA. Although the issue covered by that memorandum of understanding relative to CHAMPUS beneficiaries and treatment at DVA facilities is also very large, we narrowed our testimony down. In my brief comments, I will narrow them down to one aspect and that is the veteran beneficiary who has eligibility under both the DOD and the DVA systems, yet for all intents and purposes, the door to health care in both of those systems are essentially closed for these individuals. I'm referring to the military retired veteran.

We are quite frankly and honestly disappointed with the DOD and DVA memorandum of understanding because of the cost sharing that is going to be imposed upon military retirees for care in a DVA facility. We find it very troubling that the agreement views DVA, which we consider a Federal facility, as a private sector entity. As a matter of general statement, the Non Commissioned Officers Association is opposed to any arrangement that requires co-payments for military retirees for medical care in any Federal facility. So it just kind of escapes logic that DVA was being viewed as a private sector, in our view.

In the real world, Mr. Chairman, space and resources to treat military retirees in the DOD system has just about evaporated. The situation is only going to get worse. In recent years, 42 percent of the hospital beds in DOD has been reduced and by 1987 when the current base closures that are planned and the realignment that is planned under the base closure, one third of the medical facilities

of DOD will have been reduced in 2 more years over what we had in 1988.

So on the total picture of DOD and DVA, I think it's a matter of no small significance as to how military retirees are treated when they reach age 65. They lose virtually all of their health care options at that age. They're denied health care in the military treatment facilities and since they will lose CHAMPUS eligibility at that age, the DVA option will no longer exist for them except for service-connected disabilities that they have.

It's that reality of health care for military retirees that the reason we find the terms of the June 29 MOU rather disturbing because we think where was an opportunity to honor an obligation or more precisely a promise to those people that DOD and DVA consider it entirely appropriate to impose deductibles and co-payments upon its category of longest serving veterans. Mr. Chairman, we could accept that arrangement if that same arrangement, in fact, existed for all other veterans who received VA care for non-service connected conditions, if they were subject to that same standard or some similar arrangement. We know that's not the case and we know that it's not the case in the majority of cases.

So I guess our point this morning here is this. We think there's room here for the subcommittee to serve a purpose. If a promise was made to any veteran for health care, we think that that promise was made to the military retiree, along with the obligation that we have to those with service-connected injuries. We find it troubling that military retirees are being subjected to this arrangement. We think there's room here for the committee to work. One of the problems in this and I think we've seen it demonstrated in the hearing this morning, we have a DOD system under title 10. We have a VA system under title 38. We have a Medicare system, which both DOD and DVA are seeking Medicare's funding on, which is operated under another section of law and we've got oversight committees in Congress, a multitude of them. And it seems like we can never get everybody on the same sheet of music. I think there's a grand opportunity here for the subcommittee to bring some of these parties together so that we can discuss this issue and try to fulfill legitimate obligations that were made and to try to fill those in a reasonable fashion. We would ask you to do that, Mr. Chairman. Thank you.

[The prepared statement of Mr. Rhea appears on p. 102.]

Mr. SMITH of New Jersey. Thank you, Mr. Rhea.

I will convey your kind comments to Chairman Hutchinson, and we do appreciate that.

Mr. RHEA. Thank you.

STATEMENT OF JOHN VITIKACS

Mr. VITIKACS. Good morning, Mr. Chairman, members of the subcommittee. The American Legion appreciates the opportunity to comment on the Departments of Veterans Affairs and Defense Health Care Sharing Programs. The American Legion has followed the progress of VA/DOD medical resource sharing since 1982 when Congress enacted Public Law 97-174. This law authorized the VA and DOD to enter into medical sharing agreements with facilities of the other agency. Subsequently, more specific legislation encour-

aged VA/DOD to joint venture hospital construction and a pilot program to treat CHAMPUS eligible beneficiaries at the Asheville, NC VA Medical Center. More recently, in June of this year the Departments of Veterans Affairs and Defense signed a memorandum of understanding that allows VA to become part of the provider network under DOD's TRICARE program.

The American Legion has supported the sharing of services and resources between VA and DOD since the enactment of Public Law 971-74. The major caveat to this position is that the VA and the military medical facilities must maintain their separate identities for the purpose of carrying out their distinct missions. In the view of the American Legion, this has been accomplished.

Today, VA and DOD have negotiated 670 sharing agreements representing 4,170 shared services. The American Legion supports the recent memorandum of understanding that allows VA to become part of a provider network under TRICARE. With this new agreement, VA medical centers can participate in TRICARE under the same cost access and quality of care criteria required of TRICARE's private sector providers. This new effort will be phased in over the next several years.

A June 1995 American Legion field service visit to VA Medical Center Asheville, NC included the first year's experience of the VA/DOD CHAMPUS pilot program was beneficial to both VA and DOD. There were no apparent delays, curtailment of services to VA patients, nor the denial of treatment to eligible veterans.

The Asheville VA Medical Center learned valuable lessons in CHAMPUS billing procedures during the first year's experience which will be invaluable to other similar programs. Recently, VA Medical Centers in Syracuse, NY and Indianapolis, IN have been approved for sharing agreements under CHAMPUS.

Mr. Chairman, both the VA and DOD health care systems are undergoing tremendous change. VA has begun to reorganize under its Veterans integrated service networks and DOD is in the initial stages of its TRICARE program.

Both of these systems are designed to facilitate better service to patients and to maximize resources. As VA becomes more proficient as a CHAMPUS or TRICARE provider, they will be able to use reimbursement from these programs to improve services to veterans.

Due to select base closures and the realignment of health care treatment facilities, this phenomenon will have a significant impact on DOD in providing required levels of care to retired beneficiaries and their dependents. Where feasible, it makes sense to authorize VA to contract with DOD as a TRICARE provider for eligible beneficiaries.

The most problematic of all VA DOD sharing agreements today is the joint venture program. Currently, seven VA/DOD joint venture projects are in various stages of development and operation. The first joint venture program was between the Albuquerque VA Medical Center and the Kirtland Air Force Base Hospital. This joint venture has produced favorable results for both VA and DOD. Patient care has been expanded and enhanced and many economies of scale exist which saves money for both parties.

VA provides a majority of the medical support services required by the Air Force. In turn, the Air Force provides emergency medi-

cal services for VA. VA generates approximately \$3 million in annual revenue from this joint venture which is reinvested in services to veterans.

A VA/DOD joint venture hospital project at Nellis Air Force Base, Las Vegas, Nevada opened its doors to patients in August 1994. To date, the facility has not met the expectations of its veteran clientele. In the opinion of the American Legion, both the VA and DOD have not committed sufficient resources to adequately accomplish the facility's mission. The facility is underutilized and veterans continue to be referred to VA hospitals in Southern California for routine and subspecialty care. That is not the way the hospital was intended to function. All possible efforts must be made to insure that sick veterans do not have to travel over 300 miles for medical services that are well within the capability of the Nellis facility.

Other VA/DOD joint venture projects in various stages of development or operation are in Anchorage, AK; the Fitzsimons Army Medical Center in Denver, Colorado and the David Grant Medical Center at Travis Air Force Base California. All of these sites are addressed in our prepared statement.

Mr. Chairman, a major opportunity to improve medical services for both VA and DOD beneficiaries will be missed by not providing construction funding for the proposed VA/DOD joint venture hospital at Travis Air Force base. Veterans are not being well served in the former Martinez VA Medical Center, Chatsman area for inpatient subspecialty care. The current 53-bed VA presence at the David Grant Medical Center represents only a partial solution to the on-going problems created by the closure of the Martinez VAMC. The American Legion sincerely hopes that Congress will find it within its means to provide funding for the VA/DOD joint venture hospital at the David Grant Medical Center.

Mr. Chairman, in closing, the American Legion believes the joint venture projects authorized by Public Law 99-576 require additional congressional attention to assure that appropriate staff resources, health information systems and management policies are fully coordinated and made consistent at the respective headquarters' levels. Too often VA must interact with three DOD bureaucracies instead of one centralized office. Public Law 99-576 does not define how to implement and operate joint ventures. The law authorized joint ventures in terms of construction funding, but not how the joint ventures should be administered, controlled nor managed. The establishment of a national joint VA/DOD working group is essential and must be empowered to identify and resolve policy problems incurred at current or planned joint venture sites. Specific legislation may be necessary to insure the coordination of VA/DOD policies in this area.

That concludes my statement.

[The prepared statement of Mr. Vitikacs appears on p. 108.]

Mr. SMITH of New Jersey. Thank you very much. Mr. Carbonneau.

STATEMENT OF ROBERT P. CARBONNEAU

Mr. CARBONNEAU. Mr. Chairman, AMVETS would like to thank you and the members of the subcommittee for holding this hearing.

We at AMVETS have a vested interest in the potential for improved access to health care for military retirees and their families. The delegates attending AMVETS 51st National Convention in August of this year adopted a resolution fully supporting the continuation and expansion of VA/DOD health care sharing agreements. I have included a copy of this resolution at the end of my statement.

Sharing agreements between VA and DOD are opportunities to provide better services. Depending on the particular location and resources, VA can provide services which are unavailable at military treatment facilities and the reverse is also true. Sharing resources eliminates duplication of services and provides a cost savings for VA, DOD and ultimately the taxpayer. The VA's integrated service network health care organization presents increased opportunities for VA and DOD to work together.

AMVETS is optimistic that cooperation between VISN directors and military medical facility directors will improve patient services at a reasonable cost. Furthermore, sharing will make possible a coordinated continuum of health care during an era of budget balancing.

We are encouraged by the results of the CHAMPUS pilot project conducted at the Asheville VA Medical Center. I'm pleased to inform you that AMVETS received no negative feedback from our membership on that project. AMVETS has had a long-standing concern for our aging veterans' population as well as an appreciation of the importance to address the special needs of women veterans. Of the 1,630 CHAMPUS beneficiaries who have registered, 32 percent are 60 years of age or older and 58 percent are women. With regard to the patient over 60 years old, AMVETS is disturbed by the mandatory transition that must be made when CHAMPUS benefits run out at age 65. This aspect of a continuum of care for non-service connected veterans is neither clear nor certain. We have no doubt that the VA philosophy would be to continue care to establish patients after their CHAMPUS eligibility runs out. We are concerned, however, that because of the way Medicare laws are written, the VA Secretary's hands are tied. With this situation in mind, AMVETS would ask this subcommittee to look closely at the feasibility of allowing VA to pursue with the Health Care Financing Administration some means of Medicare reimbursement. This would be in keeping with the provision of a full continuum of care to our aging veterans.

AMVETS does not have a clear understanding of how VA's involvement in TRICARE will affect military retirees and their families enrolled in HMOs or PPO managed care CHAMPUS provider plans. Will they be automatically rolled into the TRICARE scenario? Retired veterans in this situation will need to have facts so they can choose intelligently among the options available to them.

While AMVETS is confident that VA/DOD resource sharing is beneficial to all concerned, we feel strongly that three factors must be considered in the long term. Eligibility reform must take place to enable VA to take on the added responsibility of treating CHAMPUS eligible patients. VA and DOD need to take a closer look at community based resources as a method to reaching out to broader veterans population. DOD also needs to be reminded that

it cannot wash its hands of its responsibility to provide quality health care to its beneficiaries.

Mr. Chairman, that concludes my statement.

[The prepared statement of Mr. Carbonneau, with attachment, appears on p. 119.]

Mr. SMITH of New Jersey. Thank you very much.

STATEMENT OF BOB MANHAN

Mr. MANHAN. Thank you very much, Mr. Chairman. Will you please pass on VFW's warmest regards to Chairman Hutchinson who handled this hearing for the first two and a half hours. Being the last one up at bat it is going to be very difficult to say anything new or exciting. However, we recognize that this health care problem really cuts across three different Federal departments; the Department of Veterans Affairs, the Department of Defense and the Department of Health and Human Services.

Chairman Hutchinson asked for some ideas from the previous panelists for legislation to improve on this issue of health care. From the VFW's point of view we ask this committee to consider a bold piece of new legislation that simply says all veterans are entitled to a full continuum of health care from the Department of Veterans Affairs. At \$16 billion a year, that is about what VA health care is being funded for in 1996. There aren't very many of the 27 million living veterans who are able to benefit from the present VA health system because they lack access.

Now from a Department of Defense viewpoint, they impact directly on only one category of veteran. He is called—he or she—a military retiree. The Department of Defense is the only corporate entity in the Federal Government that cuts eliminates their employee's health care at age 65. You get nothing from the Department of Defense after age 65. Upon retiring, military retirees are entitled to CHAMPUS which has deductibles and co-payments. Retirees may, if you're lucky, be treated in a military treatment facilities on a space available basis. However, with the draw down of military installations, to include hospitals, clinics and medical staff the military retiree is seldom able to receive help in a military facility. DOD has recognized these problems and come up with a system called TRICARE. TRICARE comes in three different flavors. The one that was discussed before you took over the gavel was TRICARE Prime. A lot of people are enrolling in it, for example, in Southern California. But DOD is only executing or implementing TRICARE Prime in Region 11 which includes the two States of Oregon and Washington. TRICARE Prime by Dr. Joseph's own prior statements is very expensive. It does superimpose another layer of health care administrators into the system. It must implement the VA/DOD agreements on cost sharing and facility sharing. The Veterans of Foreign Wars is very much interested in having veterans, particularly the military retiree, be eligible for another federal family of health care programs. The long title is Federal Employment Health Benefit Program. I think the acronym is "FEHBP." All Members of Congress participate in FEHBP as do their staff. All civil servants participate in this program even after they retire and beyond age 65. The Federal Government pays between 72 and 75 percent of the annual fee. FEHBP has some unique features that

would really help the military retiree in that it has no age limitation. Military retirees, as I said earlier, at age 65, are dropped from DOD and picked up by HHS. They must go to Medicare. However, FEHBP has the widest possible choice of plans. I think each January, Federal employees have the option of selecting one of 13 or 14 FEHBP that are available. FEHBP are available anywhere in the United States and overseas. There is no pre-existing illness or disability exclusions which is very nice when one reaches the age 65. All military retirees at that age, come off CHAMPUS and enter Medicare which does not provide for an annual open enrollment season. But best of all no supplemental health insurance is needed for a FEHBP. As you recall a CHAMPUS supplemental is needed.

Thank you very much, Mr. Chairman. I'm prepared to answer any questions.

[The prepared statement of Mr. Manhan appears on p. 126.]

Mr. SMITH of New Jersey. Thank you very much for your statement. You know, it's interesting that we are talking about this DOD-VA sharing agreement. It was one of the first bills passed by the committee with Mr. Montgomery's leadership during my first term and in trying to implement, at least the spirit of it, I worked very closely with Walson Hospital at Fort Dix and the VA, Department of the Army and we actually, and I'll never forget it, I took a tour of Walson in my first term and I wanted to see what the hospital was providing and it was floor after floor of empty space and I said this is where we need to put an outpatient clinic for the veterans. I worked on it, we got all of the X's in the box and at the last minute the CO pulled the plug on it. We then moved to get a VA outpatient clinic for Brick which is now up and running, but coming full cycle we are again now working to try to get an outpatient clinic at Walson because there is excess capacity there and it's all because of this legislation. It's fulfilling its hope. There are still problems with it and I appreciate the testimony of you gentlemen, and I, like others, will have to look at the record to see what went on previous to your testimony. But to fulfill the hope of trying to maximize scarce assets, particularly now where we see cuts everywhere, including the Department of Defense bill.

I do have a couple of brief questions and then I'll yield to Mr. Bishop to see if he has any questions.

Mr. Rhea, I understand your position on co-payments to the VA under the memorandum of understanding. Could you estimate for the subcommittee how many retirees are affected and do you have a cost estimate on what this would mean to a VA facility in terms of lost revenue?

Mr. RHEA. I cannot give you a precise estimate, Mr. Chairman. I have asked those questions of both DOD and DVA. Of course, we can give you the number of retirees and their beneficiaries that have CHAMPUS eligibility. That would be fairly easy to obtain.

The response I got from VA was though that they didn't track that, but now that we have the June 29 MOU that they would make a more aggressive effort to track that. The response to me when I inquired of them though was that they didn't really care, whether the veteran had 30 seconds or 30 years, they just established the veteran eligibility and go from there.

Relative to the cost, though and I think one thing that might bear consideration in this, VA has made a lot of repeated assertions that they provide comparable quality health care at less cost than the private sector and I think those gentlemen from the regional offices that testified earlier as to their experiences of seeing CHAMPUS beneficiaries, you know, come to their facilities and enroll, that's probably one reason. They're still sharing in the cost in that, but because the care is provided at less cost, there's naturally a co-payment and that sort of thing, even though the overall deductible which still has to be met.

Let me be clear on the point I'm trying to make here this morning, Mr. Chairman. The CHAMPUS world is a big world and includes active duty people, retirees and their beneficiaries. The only point that I'm asking the committee to address this morning is for that individual who has eligibility under both systems, that military retired veteran and it seems like where this opportunity existed to do something for those people, DOD and VA missed it completely in our view.

Mr. SMITH of New Jersey. Thank you very much. You were very clear in your testimony and I thank you for that additional amplification.

Mr. RHEA. Thank you.

Mr. SMITH of New Jersey. Mr. Vitikacs, can you describe how you would envision the VA/DOD working in the group that you mentioned in your testimony, would you suggest it be housed in the VA or in the DOD?

Mr. VITIKACS. This comment was a recommendation in the Joint Task Force Report to the Nellis Air Force Base facility this summer. It was commented in the report that there currently is a lack of coordination of personnel policies, information systems between the two facilities, between the two entities. Management policies are inconsistent so I'm echoing this recommendation where a high level, an appointed task force, task group made up of VA and DOD and perhaps service organization representation should be delegated to look at problems that are current, anticipated, come up with some practical solutions to these issues and be empowered. Without that empowerment, if these recommendations on various problems are only passed to respective headquarters or to field units, there's a chance they'll fall on deaf ears, so what I'm suggesting is to establish a joint task force with service organization representation, identify problems, work through solutions to these problems and have these recommendations binding on the respective entities.

Mr. SMITH of New Jersey. Now is the VFW at the local level working actively to encourage these hearing agreements? Are there certain suggestions that come forward at the state and local level that you try to get the VA and the DOD to act on?

Mr. MANHAN. I'm not so sure I understand your question, Mr. Chairman.

Mr. SMITH of New Jersey. Has the VFW at any point identified there is something that ought to be done. There's a capacity here that if it was shared, there's a synergy here that could be realized, not unlike my own personal experience with the outpatient clinic. When I was going around, I think Secretary John Marsh at the

time, he thought it was an outstanding idea, that Walson be utilized, and it would have been one of the first to utilize this new legislation, then it was new. Was the VFW and your service officers and others identify prospects and bring them forward?

Mr. MANHAN. Yes. The answer is yes. We have a team of five VFW persons that work right out of here, Washington, DC. They're called field representatives. We've broken up the United States geographically and the field representatives go to their respective physical areas, look at VA facilities to include the hospitals, the Regional Office, a cemetery, and outpatient clinics. They write up their report. They give a copy to the VA hospital director, the Regional Office VA director, the Member of Congress whose constituency the physical plants are located in and they provide a copy to the Secretary of Veterans Affairs. We do that.

Mr. SMITH of New Jersey. That's true, but it seems to me that if everyone, especially at a time when we have less to go on, less money in the pot, in this parallel type situation that just occurred in my own district, we were able to fight and succeed in saving Lakehurst which was on the list for closure, I mean radical realignment, not full closure and what I found very troubling was that Fort Dix, Maguire and Lakehurst have done very little in terms of joint sharing and they have assets that could very easily maximize over here and over there and there's very little of that being done. Now, there is a commitment by each of the commanding officers to meet regularly to try to see what they can borrow, beg or steal from each other in order to make their own operations better. It just seems it's a mindset more than anything else. How can we plug in what you have and what we're doing? That's why I ask how the VFW and other veterans organizations, when you see something that could be used, whether or not you're coming forward with recommendations for sharing.

Mr. RHEA. We certainly through our national service officers do make those recommendations back to the VA. Our director for Veterans Services on the national level, he is continually in contact with VA and I know he takes those things back. So, yes, we do.

Mr. VITKACS. And if I may, the American Legion, similar to the VFW, we have an active field service that makes visitations around the country to VA facilities, not DOD facilities for the most part, but in our site survey reports, we identify concerns, make various suggestions, recommendations to the facility and to the respective central office and we follow up on that. I would say at this point that our organization is quite satisfied with most of the VA/DOD sharing arrangements and programs that are in place. The major problem area right now is the joint venture program and that's in our view what needs the most attention at this time.

Mr. SMITH of New Jersey. Thank you. Mr. Bishop.

Mr. BISHOP. Thank you very much. Let me thank all of you for your excellent testimony and for the job that your respective organizations do in bringing these matters to our attention, but I want to especially thank you for highlighting the plight of military retirees. It pains me a great deal for military retirees who certainly, if any veterans have done their due and have fulfilled their contract of service for them in the sunset of their lives, after age 65, to have their benefits evaporate as you so eloquently state and I would cer-

tainly ask you to keep us on track in trying to correct that wrong because in my view it is a very definite wrong and it's almost immoral and unconscionable for us to allow that to happen.

They should have their continued benefits and it should be continued at no cost to them and to transfer them to another system when they become Medicare eligible, it seems to me, where they've got to pick up deductibles and co-payments and worry about assuming costs is totally inconsistent with the commitment, although not legal, as I understand it, there certainly is a moral commitment that was made at the time they entered into that career status. I just want to thank you for bringing that to our attention and I want to ask you to continually remind us of that on a constant basis and remind your membership to remind their Members of Congress of this particular problem because I think the heat needs to be turned up and it needs to be addressed.

Mr. SMITH of New Jersey. Thank you, Mr. Bishop. I want to thank the representatives of the VSO for your fine testimony and your continued input which makes the job of the subcommittee and the full committee very worthwhile and without it, we could not do our jobs, so I thank you so much.

This hearing is adjourned.

[Whereupon, at 12:16 p.m., subcommittee was adjourned.]

A P P E N D I X

Opening Statement
for
Honorable Chet Edwards
Ranking Member
Subcommittee on Hospitals and Health Care

Hearing on VA/DoD Health Care Sharing

October 18, 1995
Room 334, CHOB

Mr. Chairman, I commend you for scheduling this hearing.

At a time that budget considerations compel us to focus increasingly on opportunities to achieve economies in Federal programs, it's particularly important, in my view, that we look carefully at the promise, the practice, and the as-yet unrealized areas of potential in VA-DoD health-resource sharing.

With the enactment of major laws dating back to 1982 (Public Law 97-174) and as recently as 1992 (Public Law 102-585), Congress has signaled the importance it attaches to cooperation between two major Federal health-care systems. The extent of that cooperation has grown substantially in the

years since the first legislation encouraging such efforts. Those who feared that either Department would lose its separate identity and be merged into the other have been proven wrong. But we should not think that the number of agreements between VA and DoD hospitals means that we have come close to realizing all that was expected, or even all that is possible. There remain barriers and disincentives that block those who want to go further. In fact, sharing of health-care resources -- in terms of service-delivery, procurements, and construction -- remains the exception rather than the rule.

This morning's hearing gives us an opportunity to determine both how far we've come and how much further we can and should still go. I look forward to our witnesses' testimony, and particularly want to welcome Mike Harwell, the new director of the Central Texas Medical Centers. Mike is doing a great job of integrating three fine VA medical centers into a single three-campus unit. He is also one of the architects of a successful joint-venture with the Air Force at the Albuquerque VA Medical Center.

STATEMENT OF THE HONORABLE JON D. FOX
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

OCTOBER 18, 1995

THANK YOU, MR. CHAIRMAN, FOR YOUR LEADERSHIP IN HOLDING THESE HEARINGS. AS WE EXAMINE WAYS TO BETTER SERVE OUR VETERANS, I AM EAGER TO LEARN MORE ABOUT EFFORTS TO IMPLEMENT VETERANS AFFAIRS/DEFENSE DEPARTMENT SHARING.

WHILE BOTH THE DEPARTMENT OF VETERANS AFFAIRS AND THE DEFENSE DEPARTMENT ARE UNDER BUDGET PRESSURES, IT IS IMPORTANT TO LOOK AT OUR CURRENT SHARING INITIATIVES AND SEE WHAT IS WORKING AND WHAT NEEDS IMPROVEMENT. I AM GRATEFUL FOR THE GUIDANCE OF THE MEDICAL PROFESSIONALS, VETERANS SERVICE ORGANIZATION LEADERS AND OTHER EXPERTS WHO WILL TESTIFY TODAY.

THANK YOU.

Statement of Rep. Michael P. Flanagan of Illinois

October 18, 1995

A handwritten signature in black ink, appearing to read "MP Flanagan", written over the printed name.

Mr. Chairman I look forward to this Hearing today. The idea of VA and DoD sharing resources is most important to help to streamline health care costs while at the same time ensuring that Veterans are given the very best health care.

The issues that will be raised at this Hearing such as, whether there are sufficient incentives in place to encourage maximum sharing, and whether at a time of substantial budget pressures both departments are deriving maximum benefits from sharing authorities are worthy of review.

I look forward to hearing what our panelists have to say on these and other issues.

United States General Accounting Office

GAO

Testimony

Before the Subcommittee on Hospitals and Health Care,
Committee on Veterans' Affairs, House of Representatives

For Release on Delivery
Expected at 9:00 a.m.,
Wednesday, October 18, 1995

VA Health Care

Efforts to Increase Sharing With DOD and the Private Sector

Statement of David P. Baine, Director
Health Care Delivery and Quality Issues
Health, Education, and Human Services Division



Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss the status and future direction of Department of Veterans Affairs' (VA) health care resources sharing with the Department of Defense (DOD) and the private sector.

Health resources sharing, which involves the buying, selling, or bartering of health care services, can be beneficial to both parties in the agreement and helps contain health care costs by making better use of medical resources. For example, it is often cheaper for a hospital to buy an infrequently used diagnostic test from another hospital than it is to purchase the needed equipment and provide the service directly. Similarly, a hospital that is using an expensive piece of equipment only 4 hours a day but is staffed to operate the equipment for 8 hours could generate additional revenues by selling its excess capacity to other providers.

In the past 15 to 20 years, we have conducted a series of reviews that have identified barriers to greater sharing,¹ problems in administering sharing agreements, and the benefits and risks involved in expanding VA's authority to share resources with the private sector. My comments this morning are based on the results of those reviews, interviews with VA and DOD officials, and review of reports on sharing prepared by the two agencies.

Specifically, we will discuss

- the origin and evolution of VA's sharing authority,
- the growth in sharing agreements, and
- challenges facing VA as it enters into more and more sharing agreements with the private sector.

RESULTS IN BRIEF

Since 1966, the Congress has broadened the types of services, beneficiaries, and providers that can be covered under VA sharing agreements, eased burdensome reimbursement provisions that discouraged VA facilities from developing sharing agreements, and allowed providing facilities to retain funds from shared services as an incentive to use excess capacities.

As a result, the number of VA facilities with sharing agreements with DOD facilities increased from 12 in 1983 to 147 in 1995. Every VA facility within 50 miles of a DOD health care facility now has one or more sharing agreements. VA has about

¹A list of related GAO testimonies and reports is in appendix I.

seven times as many agreements to provide services as it does to acquire services from DOD. By contrast, VA buys about three times as many specialized medical services from private-sector facilities as it sells.

The monetary benefits of VA/DOD sharing agreements are often difficult to quantify. VA and DOD reports on sharing do not contain data on the extent to which sharing agreements are actually used, and agency officials say few services are actually exchanged under some agreements. The recent agreement under which VA's Asheville, North Carolina, medical center provides services to CHAMPUS beneficiaries at a 5-percent discount below what DOD would otherwise pay private-sector providers, however, illustrates the potential benefits of sharing.

The recent expansion of VA sharing to include service to CHAMPUS beneficiaries, the participation of VA facilities as providers under DOD's TRICARE program, and the proposed expansion of VA private-sector sharing create challenges for VA. For example, VA facilities will have to comply with billing, utilization review, and quality assurance requirements imposed by CHAMPUS, TRICARE contractors, and private-sector health plans if it wants to serve their beneficiaries.² Similarly, VA facilities will face difficult choices on when to provide health care services directly and when to contract for such services. Although VA currently lacks much of the financial and utilization data needed to facilitate such critical decisions, it is implementing a Decision Support System (DSS) that should better enable VA to generate itemized health care bills and monitor the quality and quantity of care provided in its facilities.

BACKGROUND

VA provides health care services to eligible veterans through 173 hospitals and about 200 freestanding clinics. In fiscal year 1994, VA provided health care services to about 2.5 million veterans at a cost of about \$15.4 billion. VA provided about 1 million inpatient stays and approximately 24.4 million outpatient visits. While outpatient workload is generally increasing, acute care hospital workload is decreasing, dropping by over 50 percent during the past 25 years. As a result, many VA hospitals have excess capacity.

DOD operates 124 hospitals and over 500 clinics, providing care to active-duty personnel and, on a space-available basis,

²Utilization reviews assess the need for and appropriateness of health care services. Quality assurance refers to programs designed to ensure that patients receive high-quality health care.

other eligible beneficiaries.³ The number of DOD health care facilities is decreasing as part of the downsizing and infrastructure reductions occurring in DOD. Like VA facilities, many DOD hospitals have significant amounts of excess physical capacity.

In addition to the direct care system, DOD administers an insurance-like program called the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). CHAMPUS helps pay for medical care for nonactive-duty beneficiaries under age 65 by civilian hospitals, physicians, and other civilian providers.⁴

DOD's medical programs provide health care benefits to 1.7 million active-duty military personnel and another 6.6 million nonactive-duty beneficiaries. The total fiscal year 1995 cost of the DOD health care delivery system is over \$15 billion--\$11.6 billion for direct care services and another \$3.6 billion for CHAMPUS.

DOD is restructuring the military health care system into a managed health care program known as TRICARE. Under TRICARE, a managed care support contractor establishes an integrated network of military and civilian health care providers and offers CHAMPUS beneficiaries a triple-option health care benefit.

Beneficiaries remain eligible for the standard CHAMPUS benefit, referred to as TRICARE Standard. Under TRICARE Standard, beneficiaries pay deductibles and from 20 percent to 25 percent of the cost of their care, depending on their eligibility. A second level of benefit is TRICARE Extra. TRICARE Extra beneficiaries pay a reduced copayment when they choose a medical provider participating in the contractor's TRICARE network. The third option available is TRICARE Prime. As in a civilian health maintenance organization, beneficiaries may choose to enroll in TRICARE Prime, which provides comprehensive medical care through the contractor's integrated network of military and contracted civilian providers. TRICARE

³People eligible for military health care are active-duty members of the uniformed services, family members of active-duty military personnel, retired military personnel and their family members, and family members of deceased military personnel or retirees. The uniformed services are the Army, Navy, Air Force, Marine Corps, Coast Guard, and the Commissioned Corps of the Public Health Service and the National Oceanic and Atmospheric Administration.

⁴At age 65, beneficiaries lose their CHAMPUS eligibility and become eligible for Medicare.

Prime beneficiaries pay low enrollment fees and copayment, but must go through an assigned military or civilian primary care provider for all of their care.

Implementation of the program began in March 1995, and DOD expects to have TRICARE in place across the country by May 1997.

ORIGIN AND EVOLUTION OF HEALTH RESOURCES SHARING

To allow federal agencies' resources to be used to maximum capacity and avoid unnecessary duplication and overlap of activities, federal agencies have been authorized for over 60 years to obtain goods or services through another federal agency.⁵ The law permits two federal hospitals to enter into an interagency agreement for goods and services as long as the hospital providing the services is reimbursed the actual cost. If the services are available, it is in the best interest of the government to do so, and the services cannot be provided as conveniently or cheaply by nongovernment agencies.

VA's sharing authority was expanded to include sharing with nonfederal hospitals, clinics, and medical schools in 1960.⁶ This authority, however, had several important limitations. First, it was limited to sharing of "specialized medical resources," medical techniques, and education. Such resources included equipment, space, or personnel, which, because of cost, limited availability, or unusual nature, are either unique to the medical community or can be fully used only through mutual use. Second, VA was to be reimbursed the full cost of services provided under specialized medical resources sharing agreements. Finally, sharing agreements negotiated under this authority were not to diminish the services to eligible veterans.

Although these laws permitted federal interagency sharing they did not clearly require such sharing. In 1978,⁷ we reported that the following significant barriers precluded or discouraged federal agencies from sharing:

- In the absence of a specific legislative mandate for interagency sharing, VA had little headquarters guidance on how to share.

⁵31 U.S.C. 1535, 1536.

⁶Public Law 89-785, 38 U.S.C. 8151-57.

⁷Legislation Needed to Encourage Better Use of Federal Medical Resources and Remove Obstacles to Interagency Sharing (GAO/HRD-78-54, June 14, 1978).

- Agency regulations, policies, and procedures based on each agencies' existing legislative authority inhibited interagency sharing.
- Inconsistent and unequal methods for agencies to be reimbursed for services rendered to other agencies' beneficiaries gave hospital officials little incentive to share.

The first major step in addressing these barriers occurred in 1982 through enactment of the Veterans Administration and Department of Defense Health Resources Sharing and Emergency Operations Act.⁸ To encourage development of sharing agreements at the local level, the act stipulated that a sharing agreement negotiated by DOD and VA hospital officials would go into effect automatically unless disapproved by headquarters officials within 46 days. The act also (1) modified the prior requirement that the providing agency recover its costs of providing shared services and gave the VA authority to take into account local conditions and needs and (2) required that local facilities' allotments be credited for services provided under sharing agreements to provide an incentive for facilities with excess capacity to share medical resources.

To promote VA/DOD sharing, the act established the VA/DOD Health Care Resources Sharing Committee, composed of the Assistant Secretary of Defense for Health Affairs, VA's Under Secretary for Health, and other agency officials designated by them. The following year, VA and DOD completed a memorandum of understanding beginning the VA/DOD sharing program.

Six years after the enactment of the VA/DOD sharing act, we found that while significant progress had been made in encouraging interagency sharing, the following barriers remained:⁹

- Local VA and DOD officials did not understand that reimbursement rates could be set at less than total costs to encourage sharing.
- DOD's budgetary procedures for allocating resources to its medical facilities did not guarantee that an individual facility's allocation would be increased by the amount of VA reimbursements, discouraging some military hospitals from entering into sharing agreements with VA.

⁸Public Law 97-174, 38 U.S.C. 8111.

⁹VA/DOD Health Care: Further Opportunities to Increase the Sharing of Medical Resources (GAO/HRD-88-51, Mar. 1, 1988).

- The sharing law did not allow VA to treat the dependents of active-duty and retired members of the uniformed services.
- Military hospitals were reluctant to refer DOD beneficiaries to VA hospitals because they could not use CHAMPUS funds to pay for the care. In other words, the cost of referring a patient to a VA hospital would come out of the military hospital's funds, but the costs of referring a patient to a civilian provider would come out of CHAMPUS funds.

In 1989, the Congress enacted legislation specifically authorizing the use of CHAMPUS funds to reimburse the VA for care for CHAMPUS beneficiaries from VA medical centers under sharing agreements.¹⁰ Three years later, in 1992, the Congress enacted a temporary expansion of authority for sharing agreements that permits the treatment of all categories of DOD beneficiaries at VA hospitals.¹¹

Despite these congressional actions, differences between VA and DOD over provisions of a memorandum of understanding continued to prevent CHAMPUS beneficiaries from receiving services in VA hospitals through CHAMPUS. These differences centered mainly on whether VA's hospitals would be treated as military hospitals or as CHAMPUS civilian providers. VA wanted its hospitals to be treated as military hospitals, which involve no copayments or deductibles. In addition, it wanted to (1) bill DOD directly rather than submit bills through CHAMPUS fiscal intermediaries, (2) bill CHAMPUS on a per diem basis rather than use CHAMPUS' diagnosis-related group (DRG) system, and (3) use its own utilization management and quality review systems. DOD, on the other hand, wanted VA facilities to follow CHAMPUS procedures for seeking reimbursement by filing claims with CHAMPUS fiscal intermediaries and collecting copayments and deductibles from beneficiaries.

In October 1993, the former Chairman of the House Committee on Veterans' Affairs intervened to resolve the disagreement. After this, both parties signed a sharing agreement in December 1993 to treat CHAMPUS-eligible beneficiaries in the Asheville, North Carolina, VA medical center. Under the agreement, the Asheville VA medical center is treated as a CHAMPUS provider instead of a direct care provider, it collects CHAMPUS copayments and deductibles, and it bills through CHAMPUS fiscal intermediaries. CHAMPUS reimburses claims submitted by the Asheville VA medical center for inpatient charges at a 5-percent discount off the amount payable to civilian providers under the

¹⁰National Defense Authorization Act Fiscal Years 1990 and 1991.

¹¹Veterans Health Care Act of 1992.

CHAMPUS DRG system. DOD similarly receives a 5-percent discount off the CHAMPUS maximum allowable charge for professional services.

A broader agreement was reached in February 1994 providing a framework for future CHAMPUS/VA health care resource-sharing agreements. Additional CHAMPUS/VA sharing agreements are being developed in Indiana and New York.

The advent of DOD's TRICARE program ushered in a new era in VA/DOD sharing, largely supplanting VA/CHAMPUS sharing. On June 29, 1995, VA and DOD completed work on an agreement that allows VA facilities to compete with private-sector facilities to serve as providers under TRICARE contracts. Like private-sector providers, VA facilities will be allowed to apply to DOD's regional managed care support contractors to serve as TRICARE providers. VA facilities will be required to meet the same cost, quality, and access criteria as private-sector providers and be subject to the same utilization management and quality assurance requirements as other contractors. VA facilities would essentially become subcontractors to a DOD contractor.

Provisions in the proposed Veterans Reconciliation Act of 1995, recently approved by the House Committee on Veterans' Affairs, would further expand VA's authority to share health care resources with the private sector. Specifically, it would

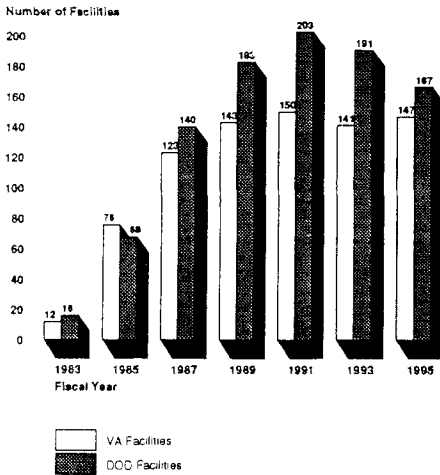
- remove the current provision that limits services that can be shared with the private sector to specialized medical resources;
- broaden the types of entities with whom VA can share to include any health care provider, health care plan, insurer, or other entity or individual;
- replace the requirement that reimbursement rates be based on actual costs of shared services with a general requirement that VA negotiate payments that are in the best interest of the government.

SHARING OF MEDICAL RESOURCES INCREASING

As barriers to sharing have been identified and addressed, VA sharing both with DOD and with the private sector continues to grow. The number of VA medical facilities with VA/DOD sharing agreements increased from 12 in 1983 to 147 in 1995. Similarly, the number of DOD facilities involved in sharing agreements increased from 16 in 1983 to a peak of 203 in 1991. Because of the closure of DOD medical facilities due to downsizing, the

number of DOD facilities with sharing agreements declined to 167 by 1995. All VA medical centers within 50 miles of a DOD hospital currently have sharing agreements. (See fig. 1.)

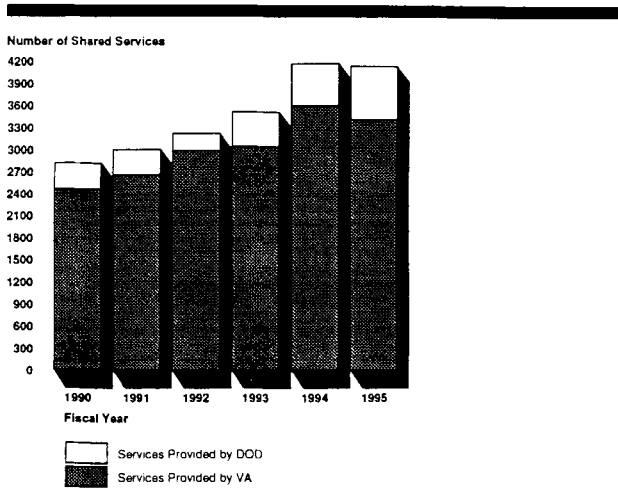
Figure 1: Number of Facilities With VA/DOD Sharing Agreements
1983-95



Note: Facilities may be hospitals or clinics.

The total number of services covered by VA/DOD sharing agreements increased from 2,815 in 1990 to 4,133 in 1995. (See fig. 2.) Most of the sharing agreements involve DOD acquiring services from VA. The portion of shared services to be provided by VA averaged over 87 percent. DOD attributes this imbalance to the fact that many of its hospitals are significantly smaller than nearby VA hospitals. In general, these smaller hospitals are more often in the position of buying services than of providing them to other facilities.

Figure 2: Total Services Covered by VA/DOD Sharing Agreements (1990-95)



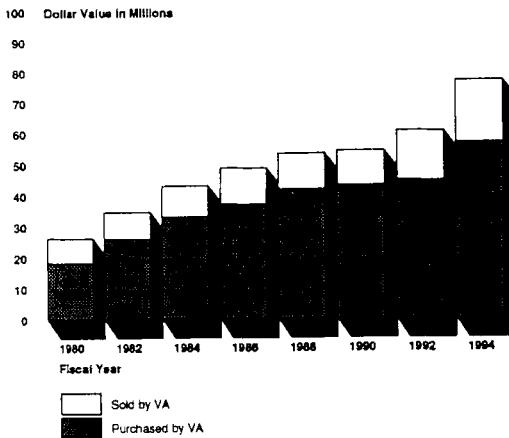
Most of this activity reflects agreements that local hospital officials initiated. Hospital-to-hospital agreements cover a range of hospital services, with most sharing involving ancillary services such as laboratory tests or diagnostic radiology procedures. Although the number of sharing agreements and the number of services covered under those agreements has grown substantially, neither VA nor DOD reports on the sharing program provide data on the volume of services actually provided.¹² Agency officials told us that some agreements generate little or no activity.

¹²At the request of the Chairman, House Committee on Veterans' Affairs, we are using a questionnaire to determine the volume of services provided to DOD beneficiaries and other nonveterans.

Specialized Medical Resources Sharing

Sharing of specialized medical resources, primarily with affiliated medical school hospitals, has also increased. Between 1980 and 1994, the value of shared services increased from \$26 million to \$77 million. Unlike sharing with DOD in which VA generally sold services, specialized medical resource sharing more commonly involves VA's purchasing services from outside providers. For example, VA reported that in fiscal year 1994 it purchased \$56.8 million worth of services from other hospitals and sold services worth \$20.3 million. (See fig. 3.) Diagnostic radiology services accounted for the greatest dollar value, \$3.9 million, of services provided by VA in fiscal year 1994. VA's largest expenditures were for radiation therapy, at slightly under \$20 million.

Figure 3: Dollar Value of VA Specialized Medical Resource-Sharing Activity (1980-94)



EXPANDED SHARING WITH PRIVATE SECTOR CREATES CHALLENGES

As VA increasingly provides services to nonveterans in VA facilities through sharing agreements and expands contracting with private-sector facilities and health plans to provide health care services to veterans, VA faces many challenges. As a seller, VA will need to meet the billing, utilization review, and quality assurance requirements of CHAMPUS, TRICARE, and private-sector health plans. In addition, it will need to set prices for its services that will make it competitive with private-sector providers without detracting from its ability to meet the needs of veterans. As a buyer, VA will need to determine when it is more economical to buy services or provide them directly, how to strengthen contract administration, how to set capitation payments when it buys services on a risk basis, and how to ensure the quality of the services it buys. However, actions by the Asheville VA medical center to develop billing procedures acceptable to CHAMPUS and allow outside utilization and quality assurance reviews demonstrate the ability of VA to address and meet such challenges.

VA Facilities Will Likely Be Required to Permit Outside Utilization and Quality Assurance Reviews

VA will likely be unable to contract to provide services to CHAMPUS beneficiaries, TRICARE contractors, or private-sector health plans and facilities unless it complies with oversight requirements established by those programs. Like private sector hospitals, VA hospitals are reviewed and accredited by the Joint Commission on Accreditation of Healthcare Organizations. But, unlike private sector hospitals, VA generally does not allow private insurers or others to perform utilization or quality-of-care reviews at its hospitals.

One of the conditions DOD placed on VA before allowing the Asheville VA medical center to contract to provide services to CHAMPUS beneficiaries was that the medical center agree to adhere to CHAMPUS utilization review and quality review systems.¹³ Under the agreement reached between VA and DOD, the Asheville medical center will maintain its own utilization and quality assurance system, but it will also be subject to CHAMPUS utilization review and quality assurance requirements. Similarly, the recently completed memorandum of understanding

¹³VA/DOD Health Care: More Guidance Needed to Implement CHAMPUS-Funded Sharing Agreements (GAO/HEHS-95-15, Oct. 28, 1994).

governing VA's participation under the TRICARE program provides that VA facilities be subject to the contractor's utilization and quality assurance requirements.

New Billing Methods Would Be Needed

One of the primary barriers VA encountered in entering into a sharing agreement to treat CHAMPUS beneficiaries was its inability to generate itemized bills and to bill using DRGs. When VA bills insurance companies, it bills on a per diem basis; that is, it bills a fixed amount per day regardless of the specific services provided.¹⁴ Similarly, it charges a fixed fee for an outpatient visit regardless of the number or types of services provided.

DOD officials told us that a condition placed on VA's participation in the CHAMPUS program was its ability to produce an itemized bill like that required of other CHAMPUS providers. A stand-alone billing system was created at the Asheville VA medical center to allow the center to enter into a CHAMPUS sharing agreement. Similar billing systems will likely need to be established at other medical centers if VA is to contract to provide services under TRICARE or through private health plans.

VA is currently implementing a DSS that will enable VA to generate itemized bills at all of its medical centers. DSS has the potential to be an effective management tool for improving the quality and cost-effectiveness of VA health care. We recently reported, however, that VA has not yet developed the comprehensive business strategy necessary to achieve such potential benefits.¹⁵ We noted that some of the data provided to DSS from other VA information systems are incomplete and inaccurate, limiting VA's ability to rely on DSS-generated information to make sound business decisions. Because of problems in ensuring the accuracy of data entered into the system, we recommended that VA slow the implementation of DSS.

Lack of Accurate Cost Data Creates Problems in Setting Prices

VA needs accurate cost data to determine appropriate prices to charge for items and services sold to private-sector facilities or health plans. If prices are set too low, funds

¹⁴Separate per diem rates are used for medical, surgical, and psychiatric care.

¹⁵VA Health Care Delivery: Top Management Leadership Critical to Success of Decision Support System (GAO/AIMD-95-182, Sept. 29, 1995).

from other sources would be needed to subsidize losses, and less money would be available to provide services to veterans. VA facilities generally cannot generate accurate cost data on items and services they provide.

The specialized medical resources sharing law does not really specify how VA is to price the medical resources it provides to medical schools, health care facilities, and research centers. The law states that reimbursement must be based on a methodology that provides appropriate flexibility to the heads of VA facilities after accounting for local conditions and needs and the actual cost of the resource involved to the providing facility.

We reported in December 1994 that the Albuquerque VA medical center sold lithotripsy services to the University of New Mexico at a price less than half of its cost of providing the service.¹⁶ We noted that the medical center's pricing practices for procedures provided to the University may affect the competitive balance among health care facilities in the Albuquerque area because the University, benefiting from VA's low reimbursement rates, was setting charges to its patients significantly below market rates. The University's reduced rates may likely shift market demand from other area hospitals to the University. Although VA agreed that the Albuquerque medical center was not recovering the full cost of lithotripsy services and that its price-setting methodology was flawed, it does not believe the rates should be increased to recover full costs.

If VA sets its prices too low because it (1) cannot determine accurate costs or (2) wants to capture market share, funds appropriated to provide care for veterans may be used to subsidize private-sector facilities and health plans purchasing services from VA. This could ultimately lead to veterans being denied needed health care services.

The lack of accurate cost data also makes it difficult for VA facilities to determine when to contract for services rather than provide them directly. Unless VA acts to improve the completeness and accuracy of data provided to DSS from other VA information systems, the usefulness of DSS-generated data in making such basic business decisions will be limited.

Overcoming Problems in Administering Contracts

VA has a long history of problems in administering specialized medical services contracts. For example, in a 1987

¹⁶VA Health Care: Albuquerque Medical Center Not Recovering Full Costs of Lithotripsy Services (GAO/HEHS-95-19, Dec. 28, 1994).

audit, VA's Inspector General reported that VA medical centers had awarded contracts for more services than were needed, paid for services they had not received, and had not established controls to ensure that contractor performance and billing complied with contract terms.¹⁷ Our July 1992 followup to the Inspector General's report found that VA still lacked sufficient data and evaluation criteria to ensure that problems were identified and corrected.¹⁸

Because VA medical centers' senior managers often receive part-time employment incomes from medical schools that receive millions of dollars through VA contracts, conflicts of interest could arise. In April 1993, we reported that these managers nevertheless participated in awarding or administering contracts with medical schools.¹⁹ Although VA has taken steps to improve the administration of sharing contracts, the effectiveness of these efforts in preventing future problems is unknown. The expanded contracting envisioned under TRICARE and the Veterans Reconciliation Act of 1995 will likely increase opportunities for conflicts to arise.

Quality Assurance Under Capitation Creates New Challenges

VA is increasingly looking to contract with individual physicians, groups of physicians, or health plans to provide health care services to veterans, often on a capitation basis. Such contracts heighten the need for VA to develop effective mechanisms to ensure the quality of services provided. Specifically, it would need to ensure that physicians are properly licensed, establish utilization reporting requirements for providers or health plans paid on a capitation basis, and establish utilization review programs to detect underservicing by risk-based providers.

Quality assurance is a particular concern under risk-based contracts because the same financial incentives that contractors have to limit unnecessary health care utilization can provide the contractor an incentive to deny needed health care services. That is, the contractor may "underserve" beneficiaries to maximize profits. Managed care programs that have been in

¹⁷Audits of Selected Aspects of VA's Program for Sharing Scarce Medical Resources, Report No: 7AM-A99-089, July 15, 1987.

¹⁸VA Health Care: Inadequate Controls Over Scarce Medical Specialist Contracts (GAO/HRD-92-114, July 29, 1992).

¹⁹VA Health Care: Inadequate Enforcement of Federal Ethics Requirements at VA Medical Centers (GAO/HRD-93-39, Apr. 30, 1993).

operation for many years, such as Arizona's Medicaid program, have developed utilization review programs that detect both overuse and underuse of health care services.

Setting Capitation Rates Will Be Difficult

Accurate cost and utilization data are critical in setting capitation payments to risk contractors. Rates set too high could result in excess profits for providers selling services to VA and increased costs for the government. Rates set too low, however, could affect the solvency of the risk contractors and lead to underservicing of veterans.

VA does not have adequate data on health care utilization to enable it to establish reasonable capitation payments to private-sector providers. VA knows the number of episodes of inpatient care and of outpatient visits, but the following problems limit the usefulness of these data in setting capitation payments:

- Because veterans do not currently enroll in the VA health care system, VA has utilization data for users but does not know how many other veterans would have used VA if they needed care. Without knowing how many other veterans would have relied on VA for health care services if they had needed care, VA will find that setting accurate capitation rates by using past VA utilization is difficult.
- VA does not know the extent to which current users rely on VA for their health care services. Over half of the Medicare-eligible veterans who used VA health care services in 1990 also used non-VA providers under Medicare. Without knowing the full health care utilization of those likely to be covered by VA capitation payments, VA will have little basis for estimating potential demand for care and setting capitation payments. In addition, to the extent that VA makes capitation payments for care to be provided to veterans covered by and using other federal health care programs, the government could end up paying twice for the same health care services. For example, if veterans covered by capitation agreements obtain services covered under the capitation agreement from other providers who subsequently bill the government under Medicare, then the government will have paid two different providers for the same care.

CONCLUSIONS

Health care resources sharing offers many benefits both to those providing and those obtaining the shared service. For those providing the service, sharing provides the opportunity to more fully utilize certain medical resources. By making its excess capacity available to others, a facility can lower its

average cost of providing services to its beneficiaries. Similarly, by purchasing services from another provider or facility, VA may be able to obtain services at a lower cost to the government than it would incur in providing the services directly. Although the benefits are hard to quantify, expanded sharing of excess health care resources should be encouraged.

Although the primary legislative barriers to increased sharing have been overcome, new barriers and challenges have emerged as the scope and types of sharing arrangements evolve and the focus of sharing shifts more toward contracting with private providers and health plans. As long as sharing is focused on the exchange of services between federal facilities, the recovery of full costs is not important. But, if VA provides services under a private contractor, as planned under TRICARE, or to private-sector facilities or health plans, pricing becomes more important. If VA does not recover its cost of providing services to nonveterans under these programs, it could result in fewer funds being available to serve veterans.

The establishment of a CHAMPUS sharing agreement in Asheville and plans to establish such agreements at two other medical centers demonstrate the ability of VA to respond to challenges such as developing itemized bills and complying with health plan utilization review and quality assurance requirements. In addition to expanding sharing opportunities, these actions should help improve the overall efficiency of VA operations.

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Mr. Chairman, this concludes my prepared statement. We will be happy to answer any questions that you or other Members of the Committee may have.

For more information on this testimony, please call Jim Linz, Assistant Director, at (202) 512-7110, or David Lewis, Evaluator-in-Charge, at (202) 512-7176.

(101482)

RELATED GAO PRODUCTS

VA Health Care Delivery: Top Management Leadership Critical to Success of Decision Support System (GAO/AIMD-95-182, Sept. 29, 1995).

VA Health Care: Challenges and Options for the Future (GAO/T-HEHS-95-147, May 9, 1995).

Barriers to VA Managed Care (GAO/HEHS-95-84R, Apr. 20, 1995).

VA Health Care: Albuquerque Medical Center Not Recovering Full Costs of Lithotripsy Services (GAO/HEHS-95-19, Dec. 28, 1994).

VA/DOD Health Care: More Guidance Needed to Implement CHAMPUS-Funded Sharing Agreements (GAO/HEHS-95-15, Oct. 28, 1994).

Veterans' Health Care: Efforts to Make VA Competitive May Create Significant Risks (GAO/T-HEHS-94-197, June 29, 1994).

VA Health Care Reform: Financial Implications of the Proposed Health Security Act (GAO/T-HEHS-94-148 May 5, 1994).

VA Health Care: Inadequate Enforcement of Federal Ethics Requirements at VA Medical Centers (GAO/HRD-93-39, Apr. 30, 1993).

VA Health Care: Inadequate Controls Over Scarce Medical Specialist Contracts (GAO/HRD-92-114, July 29, 1992).

VA/DOD Health Care: Further Opportunities to Increase the Sharing of Medical Resources (GAO/HRD-88-51, Mar. 1, 1988).

Sharing of Federal Medical resources in North Chicago/Great Lakes, Illinois, Area (GAO/HRD-81-13, Oct. 6, 1980).

The Congress Should Mandate Formation of a Military-VA-Civilian Contingency Hospital System (GAO/HRD-80-76 June 26, 1980).

Legislation Needed to Encourage Better Use of Federal Medical Resources and Remove Obstacles to Interagency Sharing (GAO/HRD-78-54, June 14, 1978).

**Statement
Before the
Subcommittee on Hospitals and Health Care,
House Committee on Veterans' Affairs**

**The Honorable Kenneth W. Kizer, M.D., M.P.H.
Under Secretary for Health**

October 18, 1995

Thank you, Mr. Chairman. I am pleased to have this opportunity to discuss with you and the members of this Subcommittee the subject of joint venturing and sharing of health care resources between the Department of Veterans Affairs (VA) and the Department of Defense (DoD).

As you know, VA and DoD have a long history of sharing health care resources. Approximately 700 specific sharing arrangements are now in place between VA and DoD. Similarly, VA has hundreds of sharing agreements in effect with our academic affiliates and a few with the Public Health Service and local and state governments. These are examples of the "virtual health care organization" that I have discussed before this Subcommittee in hearings earlier this year.

Overall, I am highly supportive of the concept behind and underlying principles of VA-DoD sharing and joint venturing--i.e., striving to achieve the most efficient use of federally-funded health care resources and get the most value possible out of taxpayer dollars used for these purposes.

During my eleven month tenure with VA, I have strongly encouraged our medical centers to make use of this tool. Exemplative of this is the memorandum of understanding (MOU) I signed with DoD on June 29, 1995, which sets the stage for

VA medical centers to be CHAMPUS providers under DoD's TRICARE program. Similarly, I have signed two additional agreements with DoD whereby specific VAMCs (Indianapolis and Syracuse) will become CHAMPUS providers contracting directly with DoD. (This is in addition to the agreement that VAMC Asheville has with DoD in this regard.) Several other sharing agreements with individual DoD facilities for selected services are also under discussion or have been finalized in recent months, as you know.

In addition to the above, and indicative of my support for the concept of expanded VA sharing and joint venturing, I might also note that in the past six months I have also signed MOUs with the Juvenile Diabetes Foundation to create VA centers of excellence in diabetes, with the Agency for Health Care Policy and Research for clinical guidelines and benchmarks development, and with the University Health Systems Consortium (UHSC) for technology assessment and clinical guidelines development. We are now discussing with UHSC the possibility of expanding this agreement in a number of ways.

Having made it clear, hopefully, that I am strongly supportive of VA-DoD (and other) sharing agreements, I need to also express some words of caution, in part derived from my experience with the private sector, as well as my previous experience in academia and state government.

In brief, there are many potential problems when you try to combine or blend entities having separate missions, cultures, and operating systems. In some cases, these are merely logistical details that can be worked out relatively easily if the involved parties are correctly motivated and the differences not too profound. In other cases, though, the differences can be so great that they

result in fatal flaws and potentially wasted time and money. In my opinion, the potential for this is certainly present in the case of VA and DoD sharing, where the primary missions of the two departments (i.e., provision of health care and military readiness) may not be complementary or optimally supportive of each other.

For a joint venture to be successful, it should be designed so that the primary purpose of the joint venture will most likely be achieved and that there will be a good return on the taxpayers' investment. For example, in joint venturing to run a hospital to serve both veterans and active duty military personnel one would want to ensure that whomever were designated to "host" the hospital had, as its primary mission, providing health care and hospital management, and that the host focused itself on providing for the most acute or intense patient care needs. For, quite simply, if one gears their activity toward taking care of the highest acuity patient care needs then it becomes managerially easy, and only at a marginal cost, to provide care for additional less sick patients. Conversely, if the host facility is geared toward taking care of low acuity patients, then they will have a much harder time gearing up to take care of high acuity (i.e., very sick and complicated) patients. There are numerous examples of this fundamental principle in other industries and activities.

Having expressed this caution, this I would note that at a time when Federal health care budgets are being constrained, we must use all tools available to provide needed health care services. Section 8111 of Title 38 is such a tool, and VA and DoD health care facility directors are now using it to provide over 4,000 shared services.

Illustrative of some recent developments in this regard, I would point out that the Bay Pines, Florida, VA Medical Center has recently engaged in an interim sharing arrangement with MacDill Air Force Base to provide a surgical suite and related services to the Air Force while MacDill's hospital undergoes renovation.

Likewise, the Navy's Office of Medical/Dental Affairs at Great Lakes, Illinois, manages payment of health care claims for active duty Navy and Marine Corps personnel throughout the nation. That Office sponsors agreements covering a full range of services whereby 43 VA medical centers provide care to active duty personnel. This successful program has grown steadily over the past four years.

In Augusta, Georgia, VA and DoD are engaged in an experimental telemedicine project. In this trial usage of the equipment, for both clinical and research applications, will produce evaluations of both the cost effectiveness and efficacy of the equipment as a diagnostic tool.

We need to do more of this sort of thing. As we move into our new VISN-based field organization, our VISN directors will be encouraged to utilize VA-DoD and other sharing authorities to make more efficient use of the resources of both departments. We believe VISNs will be able to use sharing to help improve patient services, better manage our costs, and provide a full coordinated continuum of care at a time when budgetary resources are under intense pressure.

An important aspect of VA-DoD sharing in the future, and one which I've already touched on, will be treatment of CHAMPUS beneficiaries at VA facilities.

Title II of the Veterans Health Care Act of 1992, Public Law 102-585, temporarily expanded our authority to enter into sharing agreements to provide treatment of all CHAMPUS beneficiaries. (Previously, VA-DoD sharing agreements could only be between VA and DoD health care facilities, and could not involve treatment of CHAMPUS beneficiaries who were not veterans. Previously, only retirees and active duty personnel could be cared for by VA—not dependents.) Title II also provided authority for VA health care facilities to enter into agreements with DoD's TRICARE managed care support (MCS) contractors. Under such agreements, VA facilities would become part of the contractors' provider networks for agreed upon health care services.

In 1994, Secretary Brown and then Secretary of Defense Les Aspin signed a memorandum of understanding establishing broad principles governing sharing under this expanded authority and promoting increased sharing of health care resources between the two Departments.

A pilot agreement between the VA Medical Center in Asheville, North Carolina, and DoD, to provide specific treatment and services to CHAMPUS beneficiaries in that geographic area, was signed in December 1993. This was the first sharing agreement in a DoD "non-catchment" area, and VA's initial use of the expanded CHAMPUS sharing authority.

As a result, the Asheville VAMC has been offering health care services, primarily outpatient and pharmacy, to military retirees and dependents for over a year. Asheville is reimbursed by DoD's CHAMPUS contractor (or fiscal intermediary) and uses this revenue to expand and improve service to veterans. Approximately two-thirds of the CHAMPUS patients seen so far by the VAMC

have been women. Caring for these patients has been especially helpful in improving access to services for women veterans.

I have recently signed additional CHAMPUS agreements along the lines of the Asheville model for VAMCs in Syracuse, New York, and Indianapolis, Indiana. These agreements, in locations experiencing military base closures, should provide retirees and their dependents with an attractive treatment option. In the case of Syracuse, care will be provided at the Griffith Air Force Base location, where VA has opened a community-based clinic. Discussions are underway with the CHAMPUS fiscal intermediary (AdminaStar Defense Services, Inc.) and training for VA personnel involved in billing and record keeping has been conducted.

P.L. 102-585 also gives VAMCs an opportunity to participate in DoD's managed care initiative, TRICARE. Earlier this year, as I already mentioned, I signed an MOU with DoD Assistant Secretary for Health Affairs, Dr. Stephen C. Joseph, providing the framework for agreements between VA facilities and DoD's managed care support contractors.

The VA Medical Centers in Dallas, Texas, and the Central Texas VA Health Care System (formerly Marlin, Temple, and Waco) have begun negotiations with Foundation Health Corporation to become network providers in their service areas within DoD Region 6. We are reviewing Foundation's standard provider agreement and have proposed a series of modifications to bring it into conformance with VA practices and Federal law. I anticipate that VA and Foundation will soon reach agreement on prototype language that will have nation-wide application. The prototype agreement will not include pricing or

specific services, which will be left to local negotiation. The target date for implementation of the Dallas and Central Texas agreements is November 1, 1995, the implementation date for TRICARE in Region 6.

VAMC agreements with Foundation and other MCS contractors will be subject to the safeguards contained in P.L. 102-585. This means that they will require consultation with veterans service organizations, cannot result in delay or denial of care to veterans, and must enhance service to veterans. Because I am required to certify to the Secretary that these requirements are met, these agreements will continue to require VHA headquarters review and approval.

Nowhere is VA/DoD sharing and cooperation more intense than at our eight joint venture sites. We have learned, and continue to learn, many important lessons with each of our joint venture arrangements. Interagency joint ventures, under authority of the Economy Act, have a certain conceptual appeal, but they also present numerous practical problems. Like any successful partnership, they require constant attention and communication if they are to work as intended.

In Albuquerque, New Mexico, the Air Force has operated a 30-bed unit within the Albuquerque VA Medical Center since 1987. Adjacent Air Force clinics provide outpatient and dental services. A wide variety of services are shared. Staffing there is combined in an Air Force managed emergency room and VA supervised laboratory and radiology departments.

In August 1994, VA and the Air Force opened a new 115-bed facility in Las Vegas, Nevada. While there have been significant problems in meeting the expectations of beneficiaries there, VA and the Air Force officials are working

closely together at the local and national levels to expand access to care, improve utilization of capacity, enhance efficiency of operations, and control costs. Central to our future success at this facility will be the development of a jointly developed business plan for the facility by local management, and the work of a national combined VA-DoD working group on joint ventures. I have assigned Ms. Lydia B. Mavridis, VHA's Chief Administrative Officer, the responsibility for overseeing VHA's participation in this group and assuring that joint venture problems are resolved and successful solutions disseminated.

Our third joint venture activation occurred in May 1995, when VA opened a new outpatient clinic adjacent to Reynolds Army Hospital at Fort Sill, Oklahoma. Agreements with the Army provide VA with emergency room, inpatient care, laboratory and pharmacy services, as well as maintenance, fire, and other support services.

VA and the Navy will be sharing the cost of a replacement outpatient facility at Key West, Florida. VA currently operates a small clinic at the present Naval facility there.

Additional joint ventures are planned at Anchorage, Alaska; El Paso, Texas; Travis Air Force Base, California; and Honolulu, Hawaii. VA is already staffing inpatient beds at these locations and we have a number of other sharing agreements with DoD at each site.

In the limited time I have remaining, I would like to mention some of the other areas of VA-DoD cooperation.

In the field of Information Resources Management (IRM), we are working with DoD to include VA medical facilities in Hawaii, Guam, Alaska, Washington State, and California in the Pacific Medical Network (or PACMEDNET) telecommunications project. The Federal Information Resources Sharing Working Group consists of VA, DoD, and Indian Health Service IRM personnel actively engaged in developing strategies for cooperative ventures in medical IRM. VA, DoD, and IHS jointly assess methodologies and technologies for Federal data sharing and standardization through a jointly operated Integration and Interoperability Lab in Falls Church, Virginia. And the VA-maintained Federal Health Care Resources Sharing Database provides an automated tool for planning, evaluating, and supporting the VA-DoD sharing program.

VA health care facilities also use the DoD aeromedical evacuation system. In the fiscal year just completed, 495 military patients were transported to VA medical centers. In addition, the system was used to transport 36 veterans to VAMCs for specialty care.

VA coordinates its Persian Gulf Veterans programs with both DoD and the Department of Health and Human Services through a Persian Gulf Veterans Coordinating Board. The Board consists of three working groups--dealing with clinical care, research, and compensation and benefits. The clinical group was instrumental in developing comparable health registries in VA and DoD. The research working group has produced a "Working Plan for Persian Gulf Veteran Research." This plan has served as a valuable tool for identifying research gaps and research priorities, and for avoiding duplication of research efforts.

In addition to the activities of the Persian Gulf Veterans Coordinating Board, VA has provided medical services to active duty Persian Gulf veterans under two programs: the Persian Gulf Health Registry examination and the Depleted Uranium Pilot Program. Active duty service members may receive Registry exams at VA medical facilities at the request of their DoD command. A toll-free Persian Gulf Helpline provides information on participation in VA's Registry. The VAMC in Baltimore is the site of the special pilot program for medical surveillance of those injured with depleted uranium munitions. Thirty-five soldiers were injured in a friendly fire incident and 22 of those have retained depleted uranium shrapnel. Approximately half of these remain on active duty and participate in the Depleted Uranium Program under a VA-DoD sharing agreement.

VA has had some limited success in acquiring ownership or use of DoD health care property closed through the base realignment and closure (BRAC) process. Our most notable success has been in Orlando, Florida, in which VA, the Navy, and the local reuse authority were able to effect a smooth transition that converted the Orlando Naval Hospital to a VA outpatient facility. We hope we will be able to treat some CHAMPUS workload there when the TRICARE contract for the Southeast is implemented. At Williams Air Force Base in Arizona, VA was able to establish a community based clinic through a lease arrangement with Arizona State University.

Other VA plans for properties earmarked for closure are less certain. The base disposal process is a lengthy and cumbersome one. Planning is complicated for Federal Departments and Agencies by the requirement for reimbursement of "fair market value" unless OMB waives that requirement.

In summary, I would like to express my appreciation to the House Veterans' Affairs Committee and this Subcommittee for its strong support of veterans health care in general and VA-DoD sharing in particular. I would be pleased to answer any questions.

* * * * *

STATEMENT OF
MAJOR GENERAL GEORGE K. ANDERSON, USAF, MC
DEPUTY ASSISTANT SECRETARY OF DEFENSE
(HEALTH SERVICES OPERATIONS AND READINESS)
OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
(HEALTH AFFAIRS)

BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
OCTOBER 18, 1995

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Committee on
Veterans' Affairs

Mr. Chairman, I am pleased to be here today to express to you and the members of the Subcommittee, the Department of Defense's position on a very important subject, health care resources sharing between the Department of Defense and the Department of Veterans Affairs. The Department of Defense views this sharing relationship as one of great importance and is firmly committed to its continuation and strengthening. There is a highly energized climate for sharing resulting from the positive relationship that exists between Dr. Stephen Joseph, the Assistant Secretary of Defense (Health Affairs) and Dr. Kenneth Kizer the Under Secretary for Health in the Department of Veterans Affairs. A clear example of this, is an article published recently in U. S. Medicine which they jointly authored. The article comprehensively states their position on sharing, underscores both its importance and the imperative to focus on sharing priorities and mutuality of benefit to each Department. I have a copy of the article for inclusion in the record.

Since the 1982 enactment of the sharing legislation, the headquarters and facility staffs of both Departments have jointly participated in the development and implementation of highly effective sharing programs. The substantial time and energy invested in sharing have paid off as clearly demonstrated by the continued growth and proven cost effectiveness of shared services. The more than 4,100 services shared between Department of Defense and Veterans Affairs facilities during FY1994, involving such areas as medical, surgical, laundry, blood, laboratory, radiology, and specialty care, represents a three hundred percent increase over the 1,300 services reported as shared in FY1987. In FY 1988, Department of Defense estimated its sharing-related cost avoidance to be \$9 million. In FY1994 that cost-avoidance number grew by \$11 million to an estimated \$20 million. These are dramatic increases, made especially significant as they have occurred in the face of a large number of military facility closures and a corresponding reduction in sharing agreements.

Clearly, we cannot plan for the future based solely on past successes. There have been a substantial number of facility closures, and while the Department of Defense is absorbing them, it is also adapting to rapid changes on many other fronts. So is the Veterans Health System. Indeed, both systems are being challenged to maintain the integrity of their respective mission areas while faced with increasing demands for access, fluid beneficiary populations, changes in health care modalities and substantial reductions in available health care resources. Because of these changes, our two Departments have been working very closely together to envision our long range needs and ensure that future joint efforts continue to be of mutual benefit. In other words,

neither of us can afford to engage in a relationship that benefits only one of us or inhibits our ability to function in the future. That is why the Department of Defense has agreed with the Department of Veterans Affairs to concentrate on those areas where we can support each other in the long run.

Included among these mutually beneficial areas is the developing and operating of joint venture sites. A most visible area of Department of Veterans Affairs and Department of Defense sharing has been the joint venture construction and operation of health care facilities. Joint ventures, to date, have resulted from the two Departments' local medical and construction needs coinciding to the extent that joint planning permitted significant reductions in construction and day-to-day operating costs. At present, there are eight joint ventures. The first, and most mature, joint venture is the New Mexico Regional Federal Medical Center at Kirtland AFB in Albuquerque, New Mexico which began operation since 1987. The only other fully operational location is the Nellis Federal Hospital in Las Vegas, Nevada. It became operational last year. Built to replace the Nellis Air Force Base Hospital, it is the first facility planned as a joint venture from its initial design. It is also the first joint venture not based in a medical center. The Air Force, as host, operates the 129 bed facility, but Veterans Affairs staffs 52 beds. In addition, Veterans Affairs continues to operate its Las Vegas outpatient facility.

The Albuquerque joint venture has been an invaluable source of lessons learned and undoubtedly helped in developing the Nellis operating concept. However, the complexities of these joint venture relationships make growing pains inevitable. Each joint venture is expected to be unique and the Nellis Federal Facility is no exception. It has encountered some operational issues and experienced some mis-perceptions of its capabilities. To clearly demonstrate the importance of the relationship to the senior leadership of both Departments and to provide early, durable solutions to the problems, a team led by of senior staff from both the Air Force and Veterans Affairs recently went to Nellis. The team, in extremely effective collaboration, focused on the problems and issued a detailed joint report which identifies the problems and makes appropriate recommendations for solving them. The Departments are now working together on implementing the recommendations. The lessons learned from these experiences will greatly assist in the future joint venture locations at Elmendorf, AFB in Anchorage, Alaska; Fort Bliss in

El Paso, Texas; Tripler Army Medical Center, Honolulu, Hawaii; Key West Naval Station in Florida; Fort Sill in Lawton, Oklahoma; and Travis AFB at Fairfield, California.

The second area that the Departments have agreed to focus on addresses Veterans Affairs Medical Centers as providers under both managed care support contract arrangements, as well as in certain specialized care, such as head trauma and rehabilitative care. Since the FY90 National Defense Authorization Act and the 1992 Veterans Health Care Act which together set the stage for Veterans Affairs Medical Centers to participate as CHAMPUS providers, we clearly saw the potential for increased roles for the Department of Veterans Affairs. In fact, a CHAMPUS Memorandum of Understanding facilitating implementation of these laws was signed by the Secretaries of both Departments in February 1994. Subsequently sharing agreements have been negotiated with Veterans Affairs Medical Centers at Asheville, North Carolina, Indianapolis, Indiana and Syracuse, New York.

As you undoubtedly know, the primary effort within the Department of Defense continues to be the organization of our twelve-region TRICARE program. TRICARE, through a combination of Regional Lead Agents and Managed Care Support contracts will enable us to respond to the needs of our patients and provide access to care, in a cost effective manner, with no degradation in the quality of that care. Within each region, the Lead Agent has primary responsibility for health care delivery throughout that region. The Lead Agent, in collaboration with the military treatment facility commanders, implements integrated health care delivery plans within the geographic region. Additionally, the managed care support contractor is at-risk for the delivery of CHAMPUS-beneficiary care within the region.

As the Department of Defense moves completely into TRICARE, the Asheville-like models will become outdated. As a result, the Departments of Defense and Veterans Affairs have collaborated in the construction of a memorandum of understanding which enables Veterans Affairs Medical Centers to be TRICARE network providers, should they desire to and meet the contractor's cost, access and quality criteria. This, in effect, gives our beneficiaries another choice, in addition to military and private sector providers. Those beneficiaries who prefer care from a VA Medical Center can choose to use one, as long as it meets the requirements of TRICARE and its managed care support contractors. Those VA Medical Centers that are integrated into the TRICARE contractors would then be available to our beneficiaries the same as private sector providers will be available. The beneficiaries' costs will be the same as when they

use a private sector provider. VA Medical Centers can now, for the first time, apply through managed care support contractors to become TRICARE providers. This new effort will be phased in with the two year contracting schedule.

In closing Mr. Chairman, I would like to suggest that the 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 Department of Defense 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, Department of Defense will continue to collaborate with Veterans Affairs in pursuing new sharing models to assist each Department in serving its beneficiaries in a rapidly changing health care environment.

Dr. Stephen C. Joseph and Dr. Kenneth W. Kizer

DoD and VA Joint Efforts -- Of Mutual Benefit

On June 29th, a significant event in the history of the Departments of Defense (DoD) and Veterans Affairs (VA) joint efforts took place. Not with a lot of fanfare but with a sense of common purpose, the Assistant Secretary of Defense (Health Affairs) and the Under Secretary for Health, Department of Veterans Affairs signed a memorandum of understanding. Under this agreement and for the first time, the DoD is making VA Medical Centers eligible to be reimbursed for care under Defense's new TRICARE program.

This newest effort, operating through Defense's TRICARE program, has the potential of giving DoD's CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) beneficiaries another choice, in addition to military and private sector providers serving them today. While beneficiaries can continue to use military treatment facilities and private sector providers, many may have one more option -- a VA Medical Center. Beneficiaries who prefer care from a VA Medical Center can choose to use one, as long as it meets the requirements of TRICARE and its managed care support contractors. Costs to beneficiaries will be the same as when they use a private sector provider.

With this new agreement, VA Medical Centers wishing to participate in TRICARE would apply to DoD's regional managed care support contractors and must meet the cost, access and quality criteria used by the contractors. Those VA Medical Centers striking agreements with TRICARE contractors would then be available to DoD's beneficiaries in the same way that private sector providers will be available. While this agreement does not automatically treat VA Medical Centers as TRICARE providers, for the first time it makes them eligible to apply through managed care support contractors to become TRICARE providers. This new effort with the VA will be phased in over the next two years.

This VA and DoD agreement, in the form of a memorandum of understanding, and the mechanisms it creates become the primary vehicle for VA Medical Centers wanting to provide care to DoD's CHAMPUS beneficiaries.

Why is this agreement so important? Very simply, it exemplifies the way that DoD and VA are approaching joint efforts now and into the future. The key is that VA and DoD joint efforts be of mutual benefit.

In this case, VA Medical Centers will benefit because they have the opportunity to attract not only more paying patients, but more paying patients who have much in common with the veterans already being served, yet present a more diverse set of medical conditions. At the same time DoD and its beneficiaries will benefit as beneficiaries have another option for receiving health care, in addition to Military Treatment Facilities and private sector health care providers. The more attractive, in terms of cost, access and quality, that VA Medical Centers become for DoD beneficiaries, the more DoD beneficiaries will choose VA Medical Centers.

DoD and VA are working cooperatively at all levels. The above agreement is just one example of cooperation at the highest level between the Under Secretary for Health in Veterans Affairs and the Assistant Secretary of Defense (Health Affairs). Many joint efforts have been operational for some time and many of those efforts reflect cooperation at all levels of both agencies. More joint efforts, as are described below, will come in the future.

Dr. Custis, in his June 1995 column in U.S. Medicine, points out that many joint efforts are already in place. For years, VA and DoD at all levels have engaged in a wide range of sharing arrangements built on the principle of joint efforts for mutual benefit. For example, VA and DoD have collaborated in research projects, such as traumatic brain injury, post-traumatic stress disorder, alcoholism, AIDS, spinal cord injury and sensory impairments and, most recently, illnesses that may be related to service in the Persian Gulf War.

In the area of sharing health care resources, Public Law 97-174, "The Veterans Administration and Department of Defense Health Resources Sharing and Emergency Operations Act," was specifically enacted in 1982, to promote cost-effective use of federal health care resources by minimizing duplication and underuse of health care resources while benefiting both VA and DoD beneficiaries. As a result of this legislation, the Economy Act (Title 31 USC) and administrative action, the two Departments have shared health care resources.

Since the 1982 legislation, facility-level resources sharing agreements, ranging from major medical and surgical services, laundry, blood, and laboratory services, to unusual specialty care services, have shown continued annual growth. In 1984, there were a combined total of 102 VA and DoD facilities with sharing agreements. By 1995, that number had more than doubled to 284. In two years between FY1992 and FY1994 shared services increased from slightly over 3,000 to more than 4000.

In addition to the hospital-to-hospital agreements, many education and training agreements exist between VA Medical Centers and military medical 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.

Also, for several years, the two Departments have pursued a program of joint venture construction and operation of hospitals. The first of these was the facility at Kirtland AFB in Albuquerque, New Mexico. In this joint undertaking, 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 joint effort is the new 129-bed hospital at Nellis AFB. The \$75 million FY 1990 Federal Medical Facility which replaced the old Nellis Air Force Base Hospital opened in July 1994. The Air Force is operating the facility, but VA is staffing its 52 beds. The Air Force and the VA estimate annual savings of almost \$24 million and approximately \$7 million respectively.

At the same time, VA and DoD are working together on other potential joint ventures at sites such as Travis AFB (California), Elmendorf AFB (Alaska), East Central Florida, Fort Sill (Oklahoma), Fort Bliss (Texas) and Tripler Army Medical Center (Hawaii).

How are we approaching future joint efforts? DoD and VA have decided the best strategy is to link our two networks wherever there is substantial mutual benefit. We are aggressively fielding that strategy and will continue to do so for the foreseeable future.

While this may appear obvious, not everyone seems to agree that the criteria should be mutual benefit. However, to do otherwise causes problems. There are problems if VA and DoD were to pursue joint efforts when one of the agencies and its beneficiaries may see no benefit. There are greater problems with pursuing joint efforts when both agencies and their beneficiaries may see no benefit. Neither of these latter two criteria is in the best interest of our beneficiaries or taxpayers. Instead, since there are more than enough opportunities offering mutual benefit to DoD, VA and their beneficiaries, we apply the mutual benefit criteria and focus on those opportunities meeting that criteria.

To provide a better idea of what that portends for the future, it is helpful to cite another recent agreement reached between DoD and VA. Under this informal agreement, the two agencies laid out those areas which offer the best possibility for mutual benefit. As can be seen from the following list, future joint VA and DoD efforts cover significant territory.

PRIORITIES FOR JOINT DOD/VA EFFORTS

Health systems development

- DoD and VA will develop and operate shared facilities and joint venture sites.
- DoD and VA will carry out joint planning on medical facility construction that impacts both DoD and VA beneficiaries.

Readiness

- DoD and VA will carry out joint planning for and the development of:
 - The flow of patients (injured active duty troops) within the continental U.S.
 - Specialized care for specific types of conflict-related injuries, e.g. spinal cord injury, traumatic brain injury.

Provision of Care

- DoD and VA will sign the appropriate agreements and take the necessary steps which enable the provision of medical care to DoD beneficiaries by VA Medical Centers under the CHAMPUS managed care support contracts. (Signed June 29, 1995)
- DoD and VA will work together to develop arrangements whereby DoD beneficiaries can receive appropriate specialized care (e.g. head trauma, rehabilitative care) from VA Medical Centers.

Post-deployment epidemiology, research, evaluation and care

- DoD and VA will continue their close cooperation on post-deployment (including Persian Gulf Illness) research, epidemiology, and clinical care.

Technology/Information Systems

- DoD and VA will develop joint and coordinated efforts with regard to
 - a) developing telemedicine as a means to improve readiness and patient care,
 - b) improving interoperability and interconnectivity between VA and DoD services, and
 - c) providing information management support for joint ventures.
-

With this as our joint strategy for the future, let us return to the issue of how our two networks should be linked. In this, we share the caution put forward by Dr. Custis. As he stated, "this is not to propose a single monolithic Federal Medical Service." On that point we concur. So what are we not only proposing, but actually implementing?

Paralleling what the DoD is doing within its own Military Health Services System, the VA and DoD are moving forward jointly on the development of their respective health care systems. Each agency is heavily involved in reinventing their health care systems.

For VA, that means the activation of the Veterans Integrated Service Networks (VISNs) along with a sweeping reorganization of the VA headquarters. Beginning in October of this year, the structure of both the field and headquarters of the Veterans Health Administration (VHA) will be significantly changed. In the field, the former four-region structure will give way to 22 smaller, more cohesive VISNs. These networks were chosen according to existing patient referral patterns, and groupings of facilities and patients sufficient to provide comprehensive services. The facility directors will collaborate with the VISN director to provide cost-effective care and improved patient services, and to pool resources to expand access of care to veterans. Each VISN will be headed by a director, who will have operational control, strategic planning and budgetary responsibility over all the patient care facilities and service providers in the network.

Commensurate with this decentralization of day-to-day decision making authority will be a re-engineering of VA headquarters, which will shift its focus to systemwide issues and the important function of governance of the system. This reorganization of VHA will improve efficiency, boost accountability and enhance customer service.

For DoD, reinvention, in part, means the development of TRICARE. TRICARE is DoD's regionalized managed care system, serving active duty troops and their families and retirees and their families. Moving away from the traditional workload based system, TRICARE moves toward capitation. Under capitation, the system will focus on funding Military Treatment Facilities and managed care support contractors per enrolled beneficiary rather than on the number of visits or bed days. With that change, the incentives change for military providers and the private sector, as managed through the managed care support contractors. Providers will need to be concerned about the total care of a beneficiary, not just for this current episode and not just for current year, but potentially for year after year. Preventing illness and injury becomes very important. Beneficiary satisfaction with access, cost and quality become more important. More cost-effective management of the Military Health Services System and its Military Treatment Facilities becomes more important.

DoD made a fundamental decision as to how to bring about this change. This change was to result from a joint effort of the Army, Navy, Air Force and the Office of the Assistant Secretary of Defense (Health Affairs) (OASD(HA)). "Joint" is the key term. After all, that is how DoD carries out its military missions. That is how DoD is carrying out its health mission. Under the joint approach, the Military Services and the OASD(HA) retain their respective missions, identities, cultures, and strengths. Whenever it is to their mutual benefit, as is the case with the new TRICARE program, they join forces and work side-by-side.

So it is with the VA and DoD. They have joined forces and are working side-by-side. Both retain their identity and culture. Both play to their strengths. Both carry out their assigned mission. Both must be responsive to the American taxpayer. Both ensure that their respective beneficiaries are cared for.

Again, joint efforts are best built on the principle of maximizing mutual benefit. For DoD, VA and their beneficiaries, joint efforts have been and will continue to be of mutual benefit.



DEPARTMENT OF VETERANS AFFAIRS
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Anchorage AK 99508-2989

In Reply Refer To:

STATEMENT OF AL M. POTEET III, DIRECTOR
ANCHORAGE VA MEDICAL AND REGIONAL OFFICE CENTER
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

OCTOBER 18, 1995

Mr. Chairman and Members of the Subcommittee, I am here today at the request of the Subcommittee to share with you the experience of the Anchorage VA Medical Center (VAMC) relative to our sharing agreement and joint venture with the 3rd Medical Group, Elmendorf Air Force Base (EAFB).

Alaska, because of its immense size, distance from the Continental United States, and high cost of living, presents a variety of challenges to cope with as we deliver health care to our beneficiaries. For example, Alaska's land mass is twenty percent of the entire United States. Road systems are sparse, only one two-lane road connects the state's two largest cities, Anchorage and Fairbanks. Alaska is one of only two states in the country, the other being Hawaii, without a VA inpatient facility. VA is responsible for meeting the inpatient health care needs of Alaska's 72,000 veterans. This is done through direct provision of outpatient services at the VA clinic and through coordination

of the care by obtaining needed health services from other VA Medical Centers, the private sector and federal sharing. VA's sharing agreement with the Air Force represents 3.5 percent of the \$28 million dollar budget for purchasing non-VA health care services.

As a means of trying to meet the health care needs of Alaska's veterans, the VAMC Anchorage is in the process of planning a joint venture with the 3rd Medical Group, Elmendorf Air Force Base. This venture will be fully realized with the completion of the \$156 million replacement hospital in late 1998. In FY 95, the VA provided approximately \$11 million toward the construction of this Air Force facility. This will afford VA the use of 18 of the 110 authorized beds. We have recently activated a Joint Venture Planning Committee to develop operational plans for the implementation of the joint venture.

VA's current experience with Elmendorf is through our existing sharing agreement. VA's sharing agreement with the Air Force has resulted in many enhancements to the delivery of health care to Alaska's veterans. For example, through our sharing agreement with the Air Force, VA was able to obtain selective inpatient and outpatient services and special medical procedures from the Air Force at a cost of approximately \$1 million that otherwise would have cost VA approximately \$1.8 million to procure from the private sector. Through the sharing agreement, VA obtains emergency room services from the Air Force at a considerable cost savings. VA's negotiated charge for emergency services is \$79 per visit with the Air Force, compared with an

average cost of over \$300 per emergency room visit from the private sector. A recent Air Force study indicated that when veterans utilize emergency room services, forty percent of these visits result in hospital admission. Having the patient treated first at Elmendorf, enhances VA's ability to cost effectively manage the care.

VA's sharing agreement also provides VA physicians with the opportunity to interact with inpatients at Elmendorf. This type of inpatient experience is invaluable to VA physicians in maintaining their clinical skills.

The Air Force has recently installed a new magnetic resonance imaging (MRI) scanner. This month VA will begin utilizing MRI services. This was only possible through the pooled patient volume of the sharing agreement. This radiology agreement, which also includes computerized tomography (CT), mammograms, and ultrasounds, is projected to save VA \$335,000 in the first year.

While the sharing agreement offers VA opportunities to procure selected services at reduced costs, this arrangement is not a comprehensive solution to meeting Alaska veteran's health care needs. In order for the sharing agreement and/or the joint venture to realize its potential, that of providing for the comprehensive health care needs of federal beneficiaries, some critical barriers must be overcome. These barriers include:

- o Continuity of VA care is often jeopardized due to fluctuating access to Air Force medical specialties at 3rd Medical Group.

- o Air Force does not offer the wide range of specialties needed by the older and sicker VA patient population.

- o Air Force facilities have little incentive to treat VA beneficiaries since their budget appears to be adjusted annually to offset VA reimbursement.

- o Missions differ dramatically between VA and Air Force. The Air Force is primarily concerned with readiness and combat support. VA has a ongoing mission to meet the health care needs of the veteran.

- o Delays in receiving care are more serious in VA's population. This exacerbates the continuity and staffing issues.

- o Very different organizational cultures exist between the two agencies resulting in very different expectations.

- o Discharge planning and ongoing support system needs differ dramatically due to the very different psychosocial needs of the VA population compared to the Air Force population.

- o The joint venture apparently lacks a clear commitment of resources to support the activation which complicates planning.

- o Commitment at the management level can be reached but often times break down during the execution phase.

While these obstacles make establishing a successful joint venture difficult, it is my belief that we can overcome them through a renewal of commitment by VA and DoD at the highest levels, to facilitate and support the joint venture process. This

is especially important in a time of uncertain budgetary allocations.

In closing, Alaska VA has entered into a federal health care partnership with Indian Health Service, Coast Guard, and the Department of Defense, which will be a model for sharing within the federal sector. Attached to my statement is a copy of the partnership joint logo and memorandum of understanding which is part of an 80 page document.

Thank you very much for inviting me to testify today. I would be happy to answer any questions the Subcommittee Members may have.

Attachment

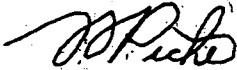


ALASKA FEDERAL HEALTH CARE PARTNERSHIP

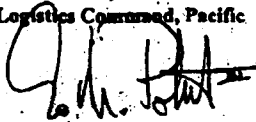
7 AUGUST 1995

We, representatives of the Alaskan medical facilities of the Indian Health Services, Department of Veterans Affairs, Coast Guard, Army Medical Department Activity-Alaska (MEDDAC-AK), and Air Force, have established a formal health care partnership to better serve the needs of our customers.

With the signing of this document we endorse the plan, its policies and principles, and hereby authorize the establishment of the Joint Executive Committee and the Strategic Planning Committee for the purposes of plan oversight.



G.G. PICHE, RADM, USCG
Commander, Maintenance and
Logistics Command, Pacific



ALONZO M. POTEET III
Director, VAM&ROC



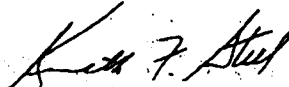
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STATEMENT OF
ALAN G. HARPER
MEDICAL CENTER DIRECTOR
DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTER
DALLAS, TEXAS
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
HOUSE OF REPRESENTATIVES

OCTOBER 18, 1995

Mr. Chairman and Members of the Subcommittee:

I am pleased to have the opportunity to discuss the Dallas Department of Veterans Affairs Medical Center's participation in TriCare. This joint venture represents a significant opportunity to build upon and complement our existing sharing initiatives with DoD. Currently, we are working in close cooperation with Foundation Health Corporation as the DoD regional managed care contractor. In this process, we have enjoyed the support of VA Headquarters, DoD Health Affairs, and Foundation Health, as we prepare for network participation in November 1995. As an alternative choice to DoD's TriCare beneficiaries, the Dallas VA Medical Center and our Fort Worth Satellite Outpatient Clinic (OPC) will provide accessible, high quality, and cost-effective care, consistent with DoD criteria and community standards. Our participation as a TriCare provider highlights the natural relationship between VA and DoD beneficiaries who share the common bond of military service. It is also on this basis that we have received the unwavering support of both the Greater Dallas Veterans Council and Tarrant County Veterans Council as we enter into this initiative.

Significant benefits are associated with our participation as a TriCare provider. Of first and foremost importance, is the opportunity for revenue generation. In these times of scarce resources, it is imperative that we have the ability to generate supplemental funding in support of enhancing veteran access to care. The revenue generated from our participation will be reinvested to expand health prevention and screening initiatives, community access to primary care, and the overall scope and level of services available to veteran beneficiaries. These advantages to our VA beneficiaries, and improved access and cost-effectiveness of care to

DoD, provide a win-win situation for our two federal agencies. Secondly, the more diverse array of medical conditions associated with TriCare beneficiaries, will expand the training experiences available through our graduate medical education, nursing, and allied health training programs. The increasing incidence of high risk multi-system disease in our veteran beneficiaries can be offset by a younger and healthier TriCare population of relatively lower risk. Balancing patient risk is particularly important in managing outcomes in cardiac surgery, organ transplantation, and other procedure-based programs. Job satisfaction and the recruitment and retention of highly qualified health care professionals will also be enhanced by the enriched clinical practice afforded by this diverse case-mix. While our medical center currently treats women veterans and CHAMPVA beneficiaries, the anticipated influx of women beneficiaries under TriCare will generate new economics to support the development of additional in-house services on the basis of cost-effectiveness.

As an overview to our participation as a TriCare provider, we recognize the divergent healthcare missions of DoD and VA. To maximize DoD's primary role of defense and VA's basic mission of health care, efforts should be undertaken to capitalize on our respective strengths by classifying VA health care facilities as "DoD Priority Providers" (DPPs) solely for the purposes of TriCare participation. Classification as a DPP would be based upon cost incentives to DoD, and would permit VA facilities to assume a more front-line position and expanded role within the managed care contractor's provider network. Under this concept, the contractor would be required to establish referral mechanisms to ensure optimal utilization of VA as well as DoD MTF facilities and resources. MTFs would be contacted as "first-line" providers, followed by VA facilities as "second-line" providers, to determine capacity before referring TriCare beneficiaries to civilian providers. Clearly, the issues and details associated with the concept of classifying VA health care facilities as DPPs for the purposes of TriCare participation require joint discussions between VA and DoD. However, the implications of this concept based on cost-effectiveness, quality patient outcomes, and advantages to VA and DoD's respective beneficiary populations must be appreciated and underscored. The Dallas VA Medical Center and our Fort Worth (PC) would welcome the opportunity to participate with the Lead Agent's office in DoD Region VI in piloting the DPP concept as a "joint demonstration project."

That concludes my statement, Mr. Chairman. I will be pleased to answer any questions you or members of the Subcommittee may have.

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TESTIMONY BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
HOUSE VETERANS AFFAIRS COMMITTEE
OCTOBER 18, 1995

BY

JAMES A. CHRISTIAN, FACHE
DIRECTOR, VA MEDICAL CENTER
ASHEVILLE, NORTH CAROLINA

Mr. Chairman, thank you for the opportunity to provide testimony on this important issue of VA/DOD sharing. I currently serve as director of a 275 bed VA medical center, with a 120 bed nursing home. Last year we treated 6000 inpatients and approximately 90,000 outpatients. Our hospital is affiliated with Duke University and we provided all levels of care including heart surgery. Our veterans come to us from western North Carolina, Tennessee, Virginia, and upstate South Carolina, and our service area includes over 100,000 veterans. It is particularly important for you to know that a large number of military retirees are located in this region, yet there is no direct military health care facility nearby.

Many of these military retirees had expressed frustration in their inability to obtain health care at the VA Medical Center Asheville. They are non-service connected and above the means test eligibility. In 1992 I appeared before this committee expressing our desire to serve these veterans under a sharing agreement with the Department of Defense. In the fall of 1992, you authorized the VA to establish some pilots to allow CHAMPUS eligibles to be served by VA medical centers on a space available basis. Our hospital was selected for such a pilot, and it began in March, 1994.

We have now had over one year's experience with the pilot and I would like to tell you about our experiences. First and most important, no veteran has been restricted from access to care because of this pilot. We set up a primary care clinic for CHAMPUS patients and currently have 780 beneficiaries enrolled in this clinic. The staffing is supported from revenue received from DOD, other insurance sources, and patient payments. Where we have specialty clinics that are filled, we refer CHAMPUS patients to local providers. However, the primary care clinic provides a full range of services to CHAMPUS beneficiaries including diagnostic evaluations, screening tests such as pap smears, care for short-term illnesses as well as maintenance therapy for chronic diseases. The clinic is staffed by a physician, a physician's assistant and a registered nurse who see patients 2 full days and 3 half days per week. This clinical team is able to treat 18 new patients and 49 established patients each week.

We have found there are numerous opportunities to provide services to this population of patients. We currently have over 1630 CHAMPUS beneficiaries who are registered in our CHAMPUS program with an average of 66 new registrants each month. Many of these beneficiaries continue to receive care from their private sector providers but choose to have their prescriptions filled and obtain diagnostic studies such as x-rays and laboratory tests at the VA.

Inpatient treatment is also available to CHAMPUS beneficiaries. Since the program's implementation we have admitted 55 patients for a variety of problems including cancer, acute pulmonary disease, and gynecological disorders.

Under this pilot program we have agreed to accept a discounted CHAMPUS reimbursement rate which affords cost savings to DOD. CHAMPUS beneficiaries also benefit from this agreement because their cost-shares are based on a percentage of this discounted rate. We have received in excess of \$482,380 in revenue from insurance payments and beneficiary cost-shares and co-payments. Although we experienced administrative and clinical growing pains which are inherent in any new endeavor, we have reached a point in this program where the efficiency of our operations has increased and we are realizing a return on our investment in the form of revenues in excess of costs. The ways in which this revenue can be used to benefit our veteran population is currently being evaluated.

Because of this pilot, Asheville has been invited to meet bimonthly with Region 2 DOD hospital commanders. We have developed a Memorandum of Understanding that promotes sharing in our new network of hospitals, and sets forth guidance for expanded relationships. We see a real opportunity to continue to work together to better serve both of our beneficiaries. For example, we have proposed a clinic to be established in Charlotte. DOD and the VHA have no facilities in Charlotte and no managed care contract. Why not jointly establish a solicitation to local providers to provide care for VA and DOD beneficiaries?

The VA's primary mission is healthcare. We recognize DOD's primary mission is providing for the defense of the country, not healthcare. Health care for retirees and dependents is but a very small part of DOD's operational activities. Although we both have the same objective to provide care to those for whom we are responsible, we seem to be working at cross-purposes in this endeavor. In consideration of this, we would like to note some of the major barriers to expanded sharing between VA and DOD facilities are:

1. FTEE restrictions limit our expansion of internal VA resources even though funds come from DOD
2. The various uniformed services control DOD CHAMPUS funds but there is no uniformity for VA to be reimbursed by a DOD medical care facility.

3. Many barriers to VA sharing at the field level are caused by the apparent problems of the DOD services/Health Affairs in transferring CHAMPUS dollars to VA. DOD insists billing for services must go through fiscal intermediaries. DOD Health Affairs is reluctant to move to large scale implementation of pilots similar to our Asheville model. If the region lead agents could control the CHAMPUS funds for all services in the entire region, sharing would be greatly facilitated.

4. Finally, there appears to be at DOD a reluctance to expand the sharing program. This may be due to the institution of the contractor oriented Tricare program, but the 172 VA hospitals and their strategic locations throughout the country should not be discounted. Most commanders and VA medical center directors are ready to share sites and facilities, but the programs will never happen effectively unless there is an efficient way to transfer resources, particularly in the CHAMPUS area.

I appreciate the opportunity to provide remarks and would be happy to answer questions.

TESTIMONY

OF

R. MICHAEL HARWELL, FORMER DIRECTOR, ALBUQUERQUE VAMC

CURRENT DIRECTOR, CENTRAL TEXAS MEDICAL CENTERS

BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTHCARE

CONGRESS OF THE UNITED STATES

ON JOINT VENTURES AND VA'S PARTICIPATION IN TRICARE

OCTOBER 18, 1995

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

Good afternoon, I am very pleased to be here today to share with you my experiences at the Albuquerque VA Medical Center and the VA Central Texas Medical Centers concerning joint ventures and the VA's participation in TRICARE. I appreciate your interest in VA healthcare and our close working relationship with the Department of Defense in both joint ventures and TRICARE.

I was the Director of the Albuquerque VAMC from February 1990 to April 1995. During my tenure as Director, the Albuquerque VA Medical Center experienced controlled growth in the number of DOD beneficiaries treated through our Joint Venture Arrangement with Kirtland Air Force Base Hospital.

Because VA facilities retain the revenues generated by VA/DOD sharing, I was able to expand the Women's Health Program to a state of the art program. I was also able to hire additional medical staff to supplement existing programs and greatly reduce patient waiting time for treatment, for both our VA and DOD patients.

Joint ventures between Department of Veterans Affairs and Department of Defense facilities make sense. Since the initial joint venture in Albuquerque in 1987 there have been a number of other joint ventures that have taken place, with a varying degree of success. Success to me means improving patient access to care and improving the quality of care provided in a fiscally responsive manner. One part of the reason for the success at Albuquerque is that the VA hospital is a full service, tertiary care medical Center that offers veterans a full spectrum of primary and speciality care. When Kirtland Hospital co-located with the Albuquerque VA, DOD beneficiaries immediately had access to all the services of a tertiary medical facility. If one joint venture partner is a tertiary facility the Joint Venture has a better chance of success. This is because that partner can offer extensive services that meet the needs of the other partner.

Prior to the initiation of any joint venture there must be a careful assessment and clear goals established jointly by VA and DOD. Some of the more challenging issues facing decision makers in regards to proposed joint venture sites will be

billing and costing issues, dual eligible veterans, manpower issues, and computer issues, just to name a few.

On October 6, 1995, Foundation Health Corporation reviewed the Central Texas Medical Centers' credentialing and privileging program. The summary report from their review indicated 100 percent compliance with full delegation of credentialing and privileging granted. On October 16, 1995, members of my staff met with Foundation Health staff in Dallas, Texas, to review our proposal to provide care to eligible TRICARE beneficiaries. We are in the process of review at this time.

The Central Texas Medical Centers (formerly the Temple, Waco, and Marlin VAMCs, the Austin Satellite Outpatient Clinic, and the Hamilton Outpatient Clinic) in Central Texas, is a newly integrated medical facility authorized to operate 1,503 hospital beds. The bed composition is 720 in Intermediate Care, 342 in Medical, 319 in Psychiatry, 107 in Surgical, and 15 in a Blind Rehabilitation Unit. Extended geriatric care is provided in two Nursing Home Care Units with a total of 280 beds. Long term rehabilitative care is provided in a Domiciliary with a total of 408 beds.

The Olin E. Teague Veterans' Center, Temple, provides the surgical, acute medical, emergency, and speciality care support to Waco, Marlin, and Temple. The Waco VAMC is a Special Referral Facility and provides Temple, Marlin, and Austin with long-term psychiatric care support. The Thomas T. Connally VAMC, Marlin, will provide Waco, Temple, and Austin with Intermediate and Extended Care Support. The Austin Satellite Outpatient Clinic is a major provider of primary care and speciality care to a growing veteran population of approximately 100,000 in the counties surrounding the State Capitol.

A \$49.7 million delegated major construction project "Bed Replacement Building" is under construction at the Temple Integrated Facility (ICF). It will provide replacement bed space for 300 beds, primarily medical, now housed in substandard facilities. Target completion date is July 1997. A Minor Construction Project to create approximately 18,000 square feet of outpatient space has been approved

for the Temple ICF and will be built concurrent with the Bed Replacement Building.

The Waco ICF is just completing a series of major construction projects totaling \$10 million. For the past 10 years patient care buildings there have been undergoing major renovation to bring them up to a "state of the art" condition. One of these buildings is a new Outpatient Clinic for delivery of Primary Care. Construction is presently underway to refurbish Building number 7 to accommodate 100 psychiatry beds and 15 Blind Rehabilitation beds.

The Marlin ICF is also under renovation. The 5th floor has been totally renovated and expanded. This project corrected patient privacy deficiencies and provides for the upcoming conversion of this patient ward area to a 40-bed nursing home care unit. Planned is the conversion of space on the first floor to accommodate more primary care clinics, and a \$2-3 million renovation of the 3rd and 4th floors.

The Austin ICF has broken ground for an 8,800 square foot addition to the current 48,000 square foot Outpatient Clinic which will add much needed clinic space. The target completion date is summer of 1996.

The Temple ICF implemented Primary Care in October 1994 with three integrated teams. Other programs, services, or changes in the planning include: Spinal Cord Injury Outpatient Clinic, Hospice Unit, Neuropsychology Lab, Ambulatory Surgery, Cardiac Cath Lab, and in-house Radiotherapy and MRI programs.

The Waco ICF started an Intensive Psychiatric Community Care (IPCC) program with Dallas in April 1995. Also, a new Primary Care program was started in a recently renovated Building.

The Marlin ICF has implemented Primary Care and continues to operate the mobile clinic program to outlying areas in Central Texas.

Central Texas Medical Centers will provide a full range of inpatient and outpatient services (excluding services that currently do not exist such as

pediatrics and adolescent psychiatry) with pharmacy capabilities. Tertiary care will be provided at the Temple Integrated Clinical Facility (ICF), while inpatient Psychiatric care will be provided in Waco ICF. Temple ICF, Waco ICF, Marlin ICF, Austin Satellite Clinic and Hamilton Clinic have primary care components.

As you can see the CTMC has a lot to offer the currently overcrowded and medically stretched nearby military facility.

The TRICARE workload will be integrated with existing veteran workload at all sites. This integration of workload will eliminate any perception of dual standards of care. For individuals with dual VA and TRICARE eligibility, Central Texas Medical Centers will be responsible for ensuring that an individual veteran's non-discretionary VA benefits are exhausted before utilizing their CHAMPUS benefits. With regard to individuals with dual VA and TRICARE eligibility, Central Texas Medical Centers will be responsible for the following beneficiary care: all care for mandatory/non-discretionary veterans; all care for veterans for service-connected conditions; and care for any veteran which is a continuation of care for a condition previously under treatment.

In summary Mr. Chairman, I believe that joint ventures and sharing programs between the Department of Veterans Affairs and Department of Defense are good for patient care and good for veterans' programs. I also feel that the Department of Veterans Affairs should be participating in the DOD TRICARE program. Mr. Chairman, I appreciate this opportunity to discuss healthcare programs at the Albuquerque VA Medical Center and our Central Texas Medical Centers. I will be pleased to answer any questions you may have.



NCOA

Non Commissioned Officers Association of the United States of America

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STATEMENT OF

LARRY D. RHEA

DEPUTY DIRECTOR OF LEGISLATIVE AFFAIRS

BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

COMMITTEE ON VETERANS AFFAIRS

U. S. HOUSE OF REPRESENTATIVES

ON

HEALTH CARE COST SHARING

BETWEEN THE

DEPARTMENTS OF DEFENSE AND VETERANS AFFAIRS

OCTOBER 18, 1995

Chartered by the United States Congress

Mr. Chairman, the Non Commissioned Officers Association of the USA (NCOA) is particularly pleased to offer testimony on the subject of health care cost sharing between the Departments of Defense and Veterans Affairs. The Association salutes the distinguished Subcommittee Chairman for scheduling and holding this hearing.

As a point of departure for our comments Mr. Chairman, NCOA wishes to restate a position that the Association has voiced many times previously.

NCOA has and will continue to support sharing arrangements and agreements between DOD and DVA that are mutually beneficial to both departments' beneficiaries.

In restating our position on sharing agreements between DOD and DVA, it is important that NCOA amplify one other central point that is implied though not explicitly contained in the above statement.

NCOA believes strongly that dispassionate, objective fairness must prevail in striving to equitably meet the federal obligation to each department's beneficiaries.

Having reiterated the Association's basic position on sharing agreements between DVA and DOD, NCOA will confine its testimony to one issue. Although the subject of sharing agreements is much broader in scope, NCOA will comment only on an area that pertains to the relative equity accorded to different categories of veterans within the VA. In so doing, the Association believes that sharing agreements have a great potential to honor more fully medical care commitments that were indeed made to a category of beneficiary that has eligibility under both the DOD and DVA systems. *Yet, for all intents and purposes, the doors to health care in both the DOD and DVA systems are essentially closed for these individuals - the military retired veterans.*

Therefore, NCOA's testimony this morning will discuss the military retiree and TRICARE in the context of sharing agreements and, in particular, the Memorandum of Understanding (MOU) between DOD and DVA that was signed on June 29, 1995. That MOU enables DVA medical centers to become eligible for reimbursement for health care provided to Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) beneficiaries. Although the population of CHAMPUS beneficiaries is much larger, NCOA will focus on the military retired veteran in relation to this hearing.

The June 29, 1995, MOU makes DVA medical centers eligible to apply through DOD's managed care support contractors to become TRICARE providers. The military retired veteran can continue to use military treatment facilities (MTF) and private-sector providers, or those who prefer care from a DVA medical center, can be referred to or choose a TRICARE-approved DVA provider. Under the MOU, the cost to the military retired veteran will be the same as for a private-sector provider.

NCOA salutes this initiative to provide military retired veterans with an additional health care alternative. The Association is disappointed, however, with both DOD and DVA because the best interests of military retired veterans have not been well-served under the terms of the MOU. NCOA is referring to the cost that the military retired veteran will incur if care is provided in a DVA medical facility. Under the MOU, federal DVA facilities are viewed as private-sector providers and the cost to the military retired veteran will be the same as if care actually had been provided by the private-sector.

As a matter of equity among the Nation's veterans and other federal beneficiaries, NCOA is opposed to any arrangement that requires co-payments from military retirees for medical care received in a federal facility. It is particularly insulting to the Nation's category of longest serving veterans that DVA and DOD would enter into such an arrangement. It escapes logic that DVA is being viewed as a private-sector entity. It's as though DOD has ignored their end of the obligation. And, it's as though the military retiree is a veteran of the lesser order in VA.

To amplify NCOA's opposition to DVA co-payments for the military retired veteran, the overall picture of how the DOD and DVA systems currently function and who is provided care and at what cost must be viewed in its entirety.

The military retired veteran retains eligibility for care in the MTF system. That eligibility is predicated on the availability of space and resources in the MTF. Between 1988 and 1997, when base closures and realignments that are currently planned will be completed, DOD will have cut one-third of its medical facilities. DOD is being required, through lack of funds and force reductions, to systematically dismantle a great medical system that has been a national treasure. *In the real world, the space and resources to treat military retirees in the DOD system has just about evaporated. The situation is only going to worsen in the years ahead.*

The military retired veteran with service-connected disabilities is also eligible for treatment in the VA for conditions related to military service. Under current eligibility rules that govern VA health care, the military retired veteran may be treated by VA on a space available basis for conditions that are non-service connected. In these instances, the military retired veteran must be able to cover the cost of such treatment in some manner.

The recourse for the military retired veteran when MTF space and resources are not available is to seek care elsewhere utilizing their CHAMPUS eligibility. For care received outside the MTF, the military retired veteran is required to share in the cost of that care.

In the total picture of the DOD and DVA systems, it is a matter of great significance as to how the military retired veteran is cast aside upon attaining the age of 65. Military retirees lose virtually all of their health care options at age 65. They are denied health care in the MTF's and, since they lose CHAMPUS eligibility at that age, the DVA option will no longer exist, except for care for service-connected disabilities. The federal government has told the category of longest serving veterans, the military retiree, that MEDICARE, with its attendant costs and limitations, is fulfillment of any perceived obligation at age 65.

DOD likes to say it takes care of its own and goes to great lengths to say that the military retiree is still a part of the military family. That's true insofar as these people remain a part of the Nation's mobilization base. Yet, when it comes to health care military retirees are at the bottom of the priority list. In NCOA's view DOD and CHAMPUS have failed in their obligation to military retirees. Many doctors simply refuse to have anything to do with CHAMPUS.

The reality of health care for military retirees as depicted above is the reason that NCOA finds the terms of the June 29, 1995, MOU between DOD and DVA so disturbing. Where an opportunity exists to honor an obligation, or more precisely a promise for health care without cost, the DOD and DVA consider it entirely appropriate to impose deductibles and co-payments upon its category of longest serving veterans. NCOA and military retirees could more easily accept this co-payment arrangement for military retirees if, in fact, all other veterans who receive VA care for non-service conditions were subjected to the same or similar standards.

But, that is not the case. The majority of the medical care now provided by the VA is for non-serviced connected conditions and is provided without cost to the veteran. Free care can be obtained in the VA system for conditions that are not even remotely related to military service - for example, AIDS, drug or alcohol treatment. Nursing home and domiciliary care can and is provided without cost in the VA system to non-service connected veterans who may have only a small fraction of the years of military service when compared to the military retired veteran.

Yet, the non-service connected military retired veteran is classified as discretionary and space available in both the DOD and DVA systems with the added benefit of deductibles and co-payments in DVA. In effect, we have a federal DVA system that tends in many cases to reward irresponsibility while in effect punishing responsible, long-term, faithful military service.

As a recognized and fully-accredited veterans service organization, NCOA understands the mission and obligation of the DVA to the Nation's veterans. *Above all else and without question, DVA has an unalterable obligation to veterans with service-connected disabilities including the unique and specialized services provided by that Department. It is also clear to NCOA that the military retired veteran served under a promise they believed to be an unalterable federal obligation. It is more than a little troubling that DOD and DVA deem it appropriate and necessary to require co-payments from the non-service connected military retired veteran while a similar requirement is considered outrageous for other non-service connected veterans who may have only one-fifteenth, one-twentieth or one-thirtieth of the years of military service.*

NCOA wants to be clearly understood on the point we are striving to make at this hearing. NCOA does not have any quarrel with any care that is provided by VA to any veteran. As a veterans organization, NCOA has steadfastly argued for resources to adequately meet the needs of all veterans. As an Association, we will continue to do so. In so doing, *we will not overlook the military retiree as a stakeholder in the VA system.*

Therefore, NCOA believes it is necessary to remind the Subcommittee, DOD and DVA that military retirees are veterans too. *Despite arguments to the contrary, a crystal clear federal obligation was made in exchange for career military service. It says a lot about DOD and DVA when these two Departments cannot work together to honor the federal commitment to military retired veterans - that of lifetime health care, without cost.*

In the overall context of the DVA medical system, NCOA asks that the Subcommittee address this issue of charging military retired veterans for treatment received in federal DVA facilities. Secretary Brown has stated that veteran health care should be considered as part of the cost for the national defense. Perhaps, the Distinguished Chairman of this Subcommittee can persuade the Secretaries of Defense and Veterans Affairs to work together to fulfill promises that were indeed made.

Thank you.

**STATEMENT OF JOHN R. VITIKACS, ASSISTANT DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
BEFORE THE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
OCTOBER 18, 1995**

Mr. Chairman and Members of the Subcommittee:

The American Legion appreciates the opportunity to comment on the status of the Departments of Veterans Affairs (VA) and Defense (DOD) health care sharing agreements and other matters. This hearing offers an excellent occasion to examine the complexities and the mutual helpfulness of VA and DOD resource sharing.

To promote greater sharing of health care resources between VA and DOD, Congress enacted Public Law 97-174. The law authorizes VA and DOD to enter into medical sharing agreements with facilities of the other agency. More specific legislation, Public Law 99-576, encouraged VA/DOD Joint Venture hospital construction, and Public Law 102-585 authorized a pilot program for the Department of Veterans Affairs to treat CHAMPUS-eligible beneficiaries at the Asheville, North Carolina VA medical center.

The Departments of Veterans Affairs and Defense also signed a Memorandum of Understanding (MOU) in June 1995, that allows VA to become part of the provider networks under DOD's TriCare programs.

Through the end of Fiscal Year (FY) 1994, sharing agreements were in place at 144 VA facilities and 140 DOD health care treatment facilities. These facilities have negotiated 670 sharing agreements, representing 4,170 shared services. Due to a decline in available DOD health care treatment facilities, brought about by base closings and facility realignments, there was a 19% increase in shared services over Fiscal Year 1993. During FY 1994, VA provided approximately \$30 million in services to DOD and purchased about \$19 million from DOD.

The American Legion has supported both the sharing of services and resources between VA and DOD, and we support the VA/DOD Joint Venture hospital construction program, provided the VA and military medical facilities maintain separate identities for the purpose of carrying out their distinct missions. The American Legion has some concerns about the current course of the Joint Venture projects and some concerns about the effect of military downsizing on the ability of DOD to continue its long-standing mission of

providing care to active duty military and retirees and their beneficiaries.

First and foremost, VA and DOD have different health care missions and constituencies. Combined, these two federal departments receive over \$30 billion in annual appropriations to provide health care services to their respective constituents. Obviously, these departments must utilize their resources in the most cost-effective manner, and by sharing resources, where possible, military and VA hospitals can treat patients more efficiently.

Both the VA and DOD health care organizations are undergoing tremendous change. VA, under the leadership of Dr. Ken Kizer, has launched its new field reorganization, the Veterans Integrated Service Networks (VISNs), and DOD has begun implementation of its TriCare program. Both of these systems are designed to facilitate better service to patients and to maximize resources. Where feasible, it makes sense to authorize VA to contract with DOD as a TriCare provider for CHAMPUS eligible beneficiaries. Active duty military personnel affected by base closings and the realignment of facilities could possibly be treated by VA under a different contract.

The American Legion agrees with the October 1994 GAO report on the implementation of CHAMPUS-funded sharing agreements which concluded that DOD hospital commanders have been slow to apply their authority to use resource sharing agreements with VA to cut costs. According to the GAO report, the Asheville VAMC CHAMPUS pilot program was delayed nearly four years by various implementation disagreements. It has been The American Legion's observation that VA is enthusiastic toward expanding sharing agreements with DOD. Oftentimes, while VA has a centralized sharing office, it finds itself dealing with three DOD bureaucracies, namely the Army, Navy and Air Force, instead of one centralized authority. Hopefully, the past problems connected with VA/DOD sharing agreements will improve.

In order to assess the impact of select base closures and the realignment of DOD health care treatment facilities on existing or impending sharing agreements with VA facilities, including potential CHAMPUS-funded sharing agreements, The American Legion recently conducted on-site visits to the following locations: VAMC Asheville, NC; VAMC Albuquerque, NM; VAMC Indianapolis, IN; VAMC Syracuse, NY; VAM&ROC Anchorage, AK; and the VAOPC Las Vegas, NV. A brief summary of each visit follows.

VA/DOD CHAMPUS and Other Sharing Agreements**VAMC Asheville**

A June 1995 American Legion field service visit to VAMC Asheville, North Carolina, concluded the first year's experience of the CHAMPUS pilot program was beneficial to both VA and DOD. There were no apparent delays, curtailment of services to VAMC patients, nor the denial of treatment to eligible veterans, attributable to the CHAMPUS workload.

The Asheville VAMC CHAMPUS Pilot Program officially began operations on March 15, 1994, for physician services, pharmacy, laboratory, radiology, and other ancillary services. The two-year pilot agreement authorized by Public Law 102-585 will soon need to be extended.

There are over 36,000 CHAMPUS beneficiaries residing in a primarily rural area which is 160 miles from the closest military treatment facility. As of March 15, 1995, a total of 1,318 patients were registered. Through May 31, 1995, 35% of those registered have not sought services; 17% have been provided prescription services only; and 48% have received clinical and prescription services. There have been 39 inpatient admissions. New patient registrations have been increasing by approximately 80 per month. Outpatient visits have continued to increase to the point that consideration has been given to expanding operating hours from the current five half days per week to two full days and three half days.

The Asheville VAMC found that the primary care structure of the CHAMPUS program was beneficial to the implementation of their own VA Primary Care program. Although the resources obtained by VA were retained by the facility, the general consensus was that the first year was a break even experience. Savings to DOD were significant and the VAMC feels that future earnings under CHAMPUS will avail them with resources to enhance the provision of health care services to veterans.

Similar programs between VA and DOD have been negotiated at VAMCs Syracuse, New York and Indianapolis, Indiana, but are not yet operational. Other VA/DOD CHAMPUS sharing agreements could be possible in the future.

VAMC Albuquerque

On January 21, 1986, the U.S. Air Force (Kirtland Air Force Base, Albuquerque, NM) and VA entered into a joint venture in the form of a Memorandum of Understanding (MOU) which allowed for development of contracts between the parties for sharing of medical resources. As a result of this MOU, some 46 contracts have been negotiated covering a

wide array of services. On February 28, 1995, the Secretary of Defense, upon recommendation of the Base Realignment and Closure Commission (BRACC), recommended closure or realignment of 146 military bases including four hospitals and two clinics by the year 2001. Kirtland Air Force Base and Hospital were initially included on the list.

The joint-venture between Kirtland AFB and the Albuquerque VAMC has produced favorable results for both parties. Patient care has been expanded and enhanced and many economies of scale exist which saves money for both participants.

An American Legion site visit was made to VAMC Albuquerque in March, 1995, to evaluate the potential impact on veterans health care by the departure of the Air Force and the dismantling of the joint venture.

The report of visit concluded that the loss of revenue generated to VA as a result of the joint venture (approximately \$3 million annually), would impact fiscal and quality of care issues at the VAMC. The revenue created by the provision of services in areas such as clinical and anatomical laboratory, dietetics, engineering services, environmental services, IRM, some pharmacy and respiratory care services and supply, processing and distribution services, plus the loss of Air Force emergency services including Level II trauma care, would have a measurable impact.

Additionally, the report concluded that "the loss of the Air Force hospital at Kirtland AFB on military retirees and dependents must be evaluated. VA should investigate the possibility of bidding and obtaining a TriCare provider contract which would allow reimbursement for the care of the retiree-dependent beneficiaries in the event of the closure of Kirtland AFB."

Since this visit was conducted, the Kirtland AFB and hospital have been removed from the BRACC list for complete closure. Congress has decided to downsize the Air Force Base and allow the hospital to remain open. No further information on this matter was available for inclusion in this statement.

VAMC Indianapolis

In 1994, negotiations began between officials of the Department of Veterans Affairs Medical Center, Indianapolis, Indiana and the administration of Fort Benjamin Harrison (FBH), Indianapolis, Indiana regarding the continued provision, by VA, of medical care services at the Hawley Army Health Clinic after the proposed closing of FBH. The Hawley Army Health Clinic is scheduled to cease operations

on September 30, 1995. This closure was a recommendation of the Base Realignment and Closure Commission (BRACC).

Just this month, the Indianapolis VAMC was approved to establish a VA/DOD CHAMPUS agreement with the Hawley Army Health Clinic, similar to the Asheville VA/DOD CHAMPUS program. Once fully established, the Indianapolis VAMC will be able to treat CHAMPUS beneficiaries. There are about 40,000 eligible beneficiaries in the 100 mile radius of Fort Benjamin Harrison and about 17,000 within 50 miles. Current utilization of the Hawley Army Health Clinic averages about 10-12,000 visits per year.

The Indianapolis VAMC consists of a modern, well kept facility with a new patient tower. The facility director has designated newly constructed clinic space within the outpatient area where military retirees, their dependents and active duty personnel would receive outpatient care. This space will have dedicated personnel and modern radiology and laboratory facilities are available.

From a quality of care and fiscal perspective, the recently negotiated CHAMPUS agreement between VA and Fort Benjamin Harrison represents a viable solution for CHAMPUS beneficiaries in relation to the closure of the Hawley Army Health Clinic.

VAMC Syracuse

The Syracuse VA medical center is a complex, tertiary care facility offering a wide range of medical and psychological services. The hospital is affiliated with the State University of New York Health Sciences at Syracuse. A VA/DOD CHAMPUS agreement, similar to the Asheville VA/DOD program, was just approved (September 1995) for the facility to treat DOD beneficiaries who previously received care from the vacated Griffiss Air Force Base Hospital. The agreement enables VA to provide health care to an estimated 10,000 DOD beneficiaries in the vicinity of Rome, New York.

The major issue remaining to be resolved in connection with the CHAMPUS sharing agreement is deeding the former Griffiss Air Force Base Hospital property to VA at no cost. A waiver from DOD is necessary to affect this property transfer.

VA/DOD Joint Venture Projects

Nellis Air Force Base Hospital

The VA/DOD Joint Venture hospital project at Nellis AFB opened its doors to patients in August 1994. An April 1985 economic analysis of VA and DOD health care needs in the Las Vegas area led to the development of the joint venture hospital. The current bed distribution of the facility

includes 63 AFB beds and 52 VA beds. VA maintains 36 medical/surgical beds, 14 psychiatric beds and two intensive care beds.

A site visit was made to the Nellis Federal Hospital (NFH) by officials of VA and the Air Force in July 1995 to review the facility's first year of operations and to assess existing concerns. The report of the visit concluded that due to a variety of organizational considerations and the dissimilarity of the respective VA and DOD patient populations, the first year of combined operations has led to many frustrations.

Essentially, the hospital is underutilized. Of the 52 VA beds, the first year's average daily census was 28, or 55% of occupancy. The Air Force's average daily census for 63 beds was 14, or 22% occupancy.

The basic planning framework for implementation of the joint venture included:

- * The new facility would operate under an integrated concept, which meant that Air Force and VA resources dedicated to the joint venture would work together to provide care for both patient constituencies.
- * Major support services in the facility (e.g. laboratory and radiology) would be provided by the Air Force, and VA would purchase services based on a reasonable reimbursement schedule developed by both parties.
- * The Air Force and VA would work together to optimize staffing patterns in order to provide the broadest range of care required at a reasonable cost.
- * VA patients who require specialty surgical care not available at the Nellis facility would be referred to other VA medical centers or private hospitals as appropriate.

Both VA and the Air Force have not committed sufficient resources to accomplish the facility mission. The VA/DOD site review team found that veterans today are being referred to VA hospitals in southern California for many subspecialty medical and surgical procedures. Specifically, the following VA services are not adequate: operating room time; nuclear medicine; invasive radiology; angiography; arterial Doppler studies, and ICU capability. In addition, computerized tomography (CT) scanning, pharmacy services, and phlebotomy services are not readily available 24 hours a day. The Air Force is also unable to provide adequate ancillary support personnel to meet VA subspecialty medical care workload requirements.

The visit to assess facility operations identified several critical deficiencies with regard to both Air Force and VA needs. The functional limitations affecting the joint venture are the amount of resources committed versus the amount required.

The Department of Defense also encounters a unique problem at its health treatment facilities not usually found within VA. Its personnel are assigned to a facility for a short time, measured in months or a few years. The military treatment facility can be adversely affected by sudden national emergencies, whereby its personnel are immediately reassigned. For example, from a local VA perspective, there is no assurance of continuity in the military coverage of subspecialty services. The military may have a given capacity in a subspecialty today, but if personnel are assigned temporary duty or transferred, the base may not maintain or reinstate the same level of coverage. For this and other related contingencies, a back-up plan to continue facility operations is necessary. This became an issue during Operations Desert Shield and Desert Storm for DOD and to a lesser degree for VA.

The site visit team to NFH made a number of recommendations which are essential to improving the Nellis Federal Hospital Joint Venture project and other joint venture operations. These are:

Facility Level

1. Define and articulate the mission of NFH.
2. Enhance support services at NFH.
3. Improve communication between the Air Force and VA.
4. Develop a joint business plan for NFH.

National Level

5. Realign local incentives for joint ventures.
6. Address the issue of "pass-through" hiring.
7. Address the policy of collocating versus integrating services.
8. Establish a national joint VA/DOD working group.

These are lofty goals. It is essential, however, that each of these recommendations are successfully resolved to improve operations at the Nellis Federal Hospital and at other current or planned joint venture projects. As concluded by the site visit team, "VA and DOD must be charged and empowered to resolve specific problems encountered by joint ventures and facilities with sharing agreements."

VAM&ROC Anchorage

Approximately 73,000 veterans reside in the State of Alaska. The main VA presence is in Anchorage where a new 83,000 square foot replacement facility that houses an Outpatient Clinic (OPC) and Regional Office became operational in May 1992. This expanded the number of veterans served by VA staff as well as the types of outpatient medical care services available, such as dental, prosthetics, audiology and ambulatory surgery.

A VA/DOD sharing agreement with the nearby Elmendorf Air Force Base (EAFB) provides access to medical inpatient beds, as well as other treatment services. For example, the VA OPC does not have in-house rehabilitative services, such as physical therapy. This is the highest volume of activity obtained from EAFB. At the VA OPC, on-site clinics in orthopedics and ophthalmology are conducted using EAFB physicians.

Management is looking to enhance the bed usage at EAFB under the sharing agreement. Other initiatives being pursued are; using the EAFB emergency room as VA's primary emergency room and establishing a sharing agreement with Bassett Army Hospital for the treatment of veterans in Fairbanks, Alaska.

Construction for a new Joint Venture medical center at EAFB has begun. The target date for project completion is 1998. VA will have access to 15 medical/surgical beds at the facility. Discussions are underway as to whether VA will contribute actual staff or salary dollars for staffing coverage. Within the current budget climate, there is obvious concern about the future availability and adequacy of activation resources.

Fitzsimons Army Medical Center

The Fitzsimons Army Medical Center (FAMC), a state-of-the-art tertiary care facility, located in Denver, CO, has been placed on the Base Realignment and Closure list for closure in 1996. The VA medical center in Denver, CO, also a tertiary care center, is limited in capacity for expansion and parking facilities.

The American Legion is currently studying a VA proposal for the continued use of the Fitzsimons Army Medical Center as an expanded VA/DOD Joint Venture operation. Discussions are currently underway between VA and DOD as to the future use of FAMC.

Additionally, The American Legion adopted Resolution No. 107 at its 1995 National Convention, which would authorize the use of VA medical centers by nonservice-

connected military retirees and their dependents who are CHAMPUS or Medicare eligible, particularly in those areas where military bases with medical facilities are closing or are closed.

David Grant Medical Center, Travis AFB, California

A major opportunity to improve medical services for VA beneficiaries will be missed by not providing construction funding for the proposed VA/DOD Joint Venture Hospital at Travis AFB.

Veterans are not being well served in the former Martinez VAMC catchment area for inpatient subspecialty care. The VA Northern California Health Care System (VANCHCS) currently staffs and operates 53 beds as part of an interim sharing agreement with David Grant Medical Center (DGMCC), Travis Air Force Base. This includes 33 medical/surgical/neurology beds, 15 psychiatry and 5 combined intensive care beds.

VA has recently hired three additional physicians dedicated to DGMCC: a gastroenterologist (GI), a cardiologist and a specialist in pulmonary medicine. These additional staff have enabled VANCHCS to admit patients with acute medical conditions who would previously have been sent to other VA medical centers or community hospitals. As a result, the VA census at DGMCC has risen substantially, some days even exceeding the 53-bed capacity and overflowing into Air Force beds when they are available.

Despite the recent increase in the VA bed census at DGMCC, VA treats far fewer inpatients than it had prior to the closure of VAMC Martinez. In its last full year of operation (FY 1990), VAMC Martinez treated approximately 7,000 inpatients. This compares with a combined total of 2,718 inpatients treated in FY 1995 at DGMCC, adjacent VA medical centers, and community hospitalizations at VA expense. Clearly, the closure of VAMC Martinez has resulted in a substantial decline of patients treated in northern California. The 53-bed DGMCC interim presence provides necessary inpatient capacity, but represents only a partial solution to the ongoing problem.

The American Legion sincerely hopes that Congress will find within its means to provide the construction funding and necessary activation funding for the VA/DOD Joint Venture Hospital at the David Grant Medical Center. The veterans of northern California need a replacement hospital for VAMC Martinez.

Summary

The American Legion supports a wide range of health care resources sharing between VA and DOD. Experience of the past several years demonstrates that the sharing of VA and DOD health care services can be mutually advantageous. At a time when both health care systems are facing strict budgetary constraints, it makes sense to explore all sharing options. This must be accomplished without compromising the individual missions of each health care system.

Military retirees are veterans too. They and their dependents are authorized to receive health care services administered or provided by DOD up to the age of 65. If as a result of their military service, retirees are rated service connected disabled, they also have priority access to VA medical care. Although military recruitment literature promises health care services for life, for a service person and for their dependents, if a member serves a minimum of 20 years active duty, DOD is quick to assert that this promise has no basis in law.

Historically, health care for DOD beneficiaries has been provided by military treatment facilities (MTFs) operated by the military services. Essentially, providing free health care services for military retirees and their dependents on a space available basis has become too expensive for DOD to support.

By definition, the first priority for MTF care is the active duty population. All other DOD beneficiaries may receive MTF care on a space-available basis. Since 1966, with the beginning of the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), non active duty beneficiaries (under age 65) have been able to receive health care from civilian sources (when not available at the MTF) and share the expense of that care with DOD through the auspices of CHAMPUS.

The DOD's newest program, TriCare, gives CHAMPUS beneficiaries another choice -- managed care. While beneficiaries can continue to use military treatment facilities and private sector providers, many may have one more option, a VA medical center. Under a new VA/DOD Memorandum of Understanding, VA medical centers wishing to participate in TriCare would apply to DOD's regional managed care support contractors and must meet the cost, access and quality criteria used by contractors. Those VA facilities forming agreements with TriCare contractors would then be available to DOD's beneficiaries in the same manner that private sector providers will be available. This new effort will be phased in over the next two years.

The American Legion supports this newest VA/DOD sharing program and other existing programs as they save precious health care resources for both federal agencies. These efforts should be continued and strengthened wherever there is recognizable mutual benefit. In relation to the TriCare agreement, it is important that each VA facility providing care to DOD beneficiaries are able to retain all reimbursements.

The VA/DOD resource sharing agreements authorized by Public Law 97-174 have proven successful and should be continued.

The American Legion believes the joint venture projects authorized by Public Law 99-576 require additional congressional attention to assure that appropriate staff resources, health information systems and management policies, are fully coordinated and made consistent at the respective headquarters levels. Public Law 99-576 does not define how to implement and operate joint ventures. The law authorized joint ventures in terms of construction funding but not how the joint ventures should be administered, controlled nor managed. The establishment of a national joint VA/DOD working group is essential and must be empowered to identify and resolve policy problems incurred at current or planned joint venture sites. Specific legislation is necessary to ensure the coordination of VA/DOD policies in this area.

Mr. Chairman, that concludes our statement.



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Statement of

Robert P. Carbonneau
AMVETS National Legislative Director

before the
Subcommittee on Hospitals and Health Care
of the
Committee on Veterans Affairs

U.S. House of Representatives

on the

Veterans Health Care Sharing Between
VA and DoD

Wednesday, October 18, 1995
Cannon House Office Building
Room 334

Mr. Chairman, AMVETS would like to thank you and the members of the subcommittee for holding this hearing on VA/DoD sharing agreements. We welcome this opportunity to discuss an aspect of health care for veterans that isn't broken, doesn't need more funding, and isn't controversial.

We have a vested interest in the potential for improved access to health care for military retirees and their families. The delegates attending AMVETS 51st national convention in Cincinnati, OH, in August of this year adopted a resolution fully supporting the continuation and expansion of VA/DoD health care sharing agreements. I have included a copy of this resolution at the end of my statement.

Many of our members have completed careers in the army, navy, marine corps, air force, coast guard, national guard or reserves. The involvement of VA in DoD's TRICARE initiative adds a new alternative to military retiree family health care options. Managed care contracting will enable military retirees and their families to

have family physicians close to home instead of having to travel, sometimes great distances, with no guarantee of being seen by the same doctor twice.

Sharing agreements between VA and DoD are opportunities to provide better services. Depending on the particular location and resources, VA can provide services which are unavailable at military treatment facilities (MTF). The reverse is equally true. Sharing resources eliminates duplication of services and provides a cost savings for VA, DoD, and ultimately the taxpayer..

The VA's Veterans Integrated Service Network health care organization presents increased opportunities for VA and DoD to work together. AMVETS is optimistic that cooperation between VISN directors and military medical facility directors will improve patient services at a reasonable cost. Furthermore, sharing will make possible a coordinated continuum of health care during an era of budget balancing.

We are encouraged by the results of the CHAMPUS pilot project conducted at the Asheville (North Carolina) VA Medical Center from March, 1994 through September, 1995. Under the pilot program, those 18 years of age or older who are CHAMPUS eligible participate and receive their health care at VAMC Asheville. Beneficiaries receive treatment from the primary care clinic, or they could receive specialty and/or ancillary services at other nearby facilities. They could also have the option of having their prescriptions filled at the pharmacy. A total of 1,630 participants enrolled during the course of the 18-month program. I'm pleased to inform you that AMVETS received no negative feedback from our membership on this project.

AMVETS has had a long-standing concern for our aging veteran population, as well as an appreciation of the need to address the special needs of women veterans. Of the 1630 CHAMPUS beneficiaries who have registered, 32 percent were 60 years of age or older and 58 percent were women. With regard to the patients over 60 years old, AMVETS is disturbed by the mandatory transition that must be made

when CHAMPUS benefits run out at age 65. This aspect of "a continuum of care" for non-service-connected veterans is neither clear nor certain. We have no doubt that the VA philosophy would probably be to continue care to established patients after their CHAMPUS eligibility runs out. We are concerned, however, that because of the way medicare laws are written, the VA Secretary's hands are tied. With this situation in mind, AMVETS would ask this subcommittee to look closely at the feasibility of allowing VA to pursue with the Health Care Financing Administration some means of medicare reimbursement. This would be in keeping with the provision of a full "continuum of care" to our aging veterans.

There are other positive results of the Asheville VAMC pilot project. Asheville collected more than \$480,000 since the program was implemented. Furthermore, results of a patient survey conducted earlier this year show beneficiaries rated their care at VAMC Asheville as good as or better than treatment they had previously received from private sector or military treatment facilities. Finally,

new patient enrollment in the project averaged sixty-five or more per month even though there was no formal marketing program to generate business. This proves that customer satisfaction breeds a new customer base.

AMVETS does not have a clear understanding of how VA's involvement in TRICARE will affect military retirees and their families enrolled in "HMO" or "PPO" managed care CHAMPUS provider plans. Will they be automatically rolled into the TRICARE scenario? Retired veterans in this situation will need to have facts so they can choose intelligently among the options available to them.

While AMVETS is confident that VA/DoD resource sharing is beneficial to all concerned, we feel strongly that three factors must be considered in the long term. Eligibility reform must take place to enable VA to take on the added responsibility of treating CHAMPUS-eligible patients. VA and DoD need to take a closer look at community-based resources as a method of reaching out to a broader veterans population. DoD also needs to be reminded that it cannot wash its

hands of its responsibility to provide quality health care to its beneficiaries.

Mr. Chairman, this concludes my statement.



RESOLUTION 95-36
VA AND DoD HEALTH CARE SHARING



WHEREAS the VA operates the largest health care system in the U.S., and the DoD operates the 2nd largest health care system in the U.S.; and

WHEREAS many military bases and medical treatment facilities are in areas where there is a large veteran and military retiree population; and

WHEREAS the closure of DoD medical treatment facilities will have a drastic impact on military retirees and their families; and

WHEREAS it would be cost-effective to treat military retirees and veterans in either VA or DoD medical treatment facilities; and

WHEREAS it would be mutually beneficial for VA and DoD medical facilities to enter into joint sharing agreements where there is a large veteran and military retiree population; and

WHEREAS this will assure accessibility for veterans and military retirees to health care services; now therefore

BE IT RESOLVED by AMVETS that we support more joint use sharing agreements between VA and DoD medical facilities where it would be feasible and beneficial to all veterans.

VETERANS OF FOREIGN WARS OF THE UNITED STATES



OFFICE OF THE DIRECTOR

STATEMENT OF

BOB MANHAN, ASSISTANT DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

**DEPARTMENT OF VETERANS AFFAIRS (VA) AND DEPARTMENT OF DEFENSE (DOD)
SHARING**

WASHINGTON, DC

OCTOBER 18, 1995

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

Thank you for inviting the Veterans of Foreign Wars of the United States (VFW) to participate in this very important hearing. It is a fact that the VFW has a long-standing interest in having the federal government provide a continuum of health care for our nation's veterans. It is also a fact that the VA operates the single largest health care system in the country while DoD operates the second largest. Hence, it makes good sense to have these two federal departments share medical facilities, personnel, equipment, and costs whenever and wherever possible.

To reinforce our opening remarks three current VFW resolutions are attached to this statement. Each was unanimously passed by our voting delegates at our national convention held in Phoenix, Arizona. These resolutions expresses, in the strongest possible terms, the health care interests and intentions of our 2.1 million member organization. the resolutions are: No. 607: *VA And DoD Health Care Sharing*; No. 603: *National Health Care Impact On VA*; and, No. 601: *Reform Eligibility For Access To VA Health Care*. All three have a direct bearing on today's philosophic hearing in order to

ultimately establish implementing legislation that will improve health care for veterans and reduce any duplicative costs to the American tax payer.

The "Veterans Health Care Act of 1992," signed into law as P.L. 102-585 on November 4, 1992, in part, authorized the Secretary of VA to enter into an agreement with the Secretary of DoD to expand the availability of health care sharing arrangements.

On June 29, 1995, a Memorandum of Understanding (MOU) between VA and DoD was signed. It established the general requirements for agreement between a DoD regional managed care support (MCS) contractor and a VA health care facility under which the MCS contractor may include the VA's facility in the contractor's network.

Today, there are a selected number of individuals who have a dual VA and DoD eligibility to be treated in the VA test-site at the Asheville, North Carolina, VAMC. These patients are Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) eligible beneficiaries. However, if there is third party insurance, that will be used before charging CHAMPUS as the second payer.

In an ongoing effort to improve health care services to its active duty force and military retirees, DoD has introduced in March 1995 the TRICARE Prime health benefit option. In sum, this is a new Health Maintenance Organization (HMO) program, available today only in the states of Washington and Oregon. In this geographic area those DoD CHAMPUS beneficiaries who elect to enroll in TRICARE Prime will do so for a year at a time. They will receive their health care from the Prime network of civilian and military providers. There is no enrollment fee for active duty families but an annual fee of \$460 for a family of otherwise CHAMPUS-eligible persons, i.e., a military retiree and his dependent(s).

It is our understanding that under the VA-DoD MOU those VA medical centers wishing to participate in TRICARE Prime would apply to DoD's regional MCS contractors and must first meet the cost access and quality criteria used by contractors. The VFW believes this new effort will be phased in over the next two years.

While the VFW strongly supports the concept of this hearing we do have concerns. First and foremost is that any network of expanding agreements not reduce or abolish the VA health care system.

Part of this issue is our belief that all veterans discharged under honorable conditions have earned special consideration for health care through their military service. Hence, we believe it is only proper and equitable to have a VA health care mission to provide these veterans a mandated entitlement by law to access the full continuum of health care ranging from preventive through nursing home care. This can only be accomplished by changing the present laws governing VA's health care eligibility.

The VFW recognized that while the main thrust of the MOU under discussion today will allow CHAMPUS-eligible persons to use VA facilities; CHAMPUS, itself, terminates for military retirees at age 65. Thereafter, they receive health care from Department of Health and Human Services' MEDICARE program and lose their DoD health care support system. We also note that no one in any of the three TRICARE programs -- Prime, TRICARE Extra, or TRICARE Standard all end at age 65. Again, there is no reimbursement system or mechanism for MEDICARE to pay DoD or VA for medical services. From a VA point of view they would benefit most by having all veterans eligible for a continuum of medical care with legislation allowing reimbursement or subvention from CHAMPUS, MEDICARE, and MEDICAID.

However, from a DoD point of view this is not necessarily the best solution. Please recall that the primary mission of the military health system is to maintain the health of military personnel so they can carry out their missions and to be prepared to deliver health care in time of war. The current law entitles active duty personnel and their family members, on a space-available basis, to health care at military medical treatment facilities (MTFs). Current law does not entitle military retirees and their families health care at MTFs. Rather, they may receive their care there only on a space-available basis, after military dependents. This fact negates the often heard, often repeated, and still used recruiting promise of life-time military health care for retirees and their families.

It is because of DoD's moral obligation to keep this health care promise to their retirees that DoD is studying the Federal Employee Health Benefit Program (FEHBP). In sum, FEHBP is a market based program available to all federal employees, civil service retirees and members of congress and their staff. There is a wide range of health insurance options that include fee-for-service plans -- managerial care plans, HMOs and/or Primary Provider Organizations (PPOs).

At the present time the federal government pays between 72 and 75 percent of any FEHBP selected by the beneficiary. From a military retiree's point-of-view, FEHBP appears to be very advantageous. It has no age limit, offers the widest possible choice of plans, would be available worldwide, has no pre-existing exclusions, and does provide an annual open season. Last, no supplemental health insurance would be needed.

The VFW certainly supports the concept of VA-DoD sharing. At the same time we do not believe a single alternative can fix the system for veterans and retirees. At this time we do not want to dismiss any reasonable alternatives, either individual programs or a combination of programs that will improve the system and access to medical care. However, the VFW is realistic and recognizes that the above mentioned DoD promise of free lifetime medical care has not in fact existed in practice, except for a few fortunate enough to live near a large military facility.

The VFW does support the TRICARE program with its three options and would support legislation to have MEDICARE eligible retirees and their dependents eligible to enroll and/or remain in TRICARE.

Furthermore, the VFW insists on keeping standard CHAMPUS. At present, it is the only law that gives under age 65 military retirees any option other than space available care in MTFs. In fact, military retirees are the only category of federal employees who lose their "comporate" sponsorship at age 65.

Also important to this subject is the issue of MEDICARE subvention. The VFW is now on record to have MEDICARE reimburse VA, MTFs and DoD managed care networks for Medicare eligible military retirees. Proposed subvention should include reimbursement on a fee-for-service or point-of-service basis, as well as on capitation basis, for those who enroll in the DoD HMO option.

In conclusion, the VFW believes that health care for veterans is an extremely complex topic, but that it need not be extremely expensive. Thank you, Mr. Chairman. This concludes the VFW statement. I am prepared to respond to any questions you and the committee members may have.

Resolution No. 607

VA AND DOD HEALTH CARE SHARING

WHEREAS, the VA operates the largest health care system in the U.S. and the DOD operates the 2nd largest health care system in the United States; and

WHEREAS, many military bases and medical treatment facilities are slated for closure; and

WHEREAS, some DOD medical treatment facilities are in areas where there is a large veteran and military retiree population; and

WHEREAS, the closure of DOD medical treatment facilities will have a drastic impact on military retirees and their families; and

WHEREAS, it would be most effective to treat military retirees and veterans in either VA or DOD medical treatment facilities; and

WHEREAS, it would be mutually beneficial for the VA and DOD medical facilities to enter into joint use sharing agreements where there is a large veteran and military retiree population; and

WHEREAS, this will assure accessibility for veterans and military retirees to health care services; now, therefore

BE IT RESOLVED, by the Veterans of Foreign Wars of the United States, that we support more joint use sharing agreements between VA and DOD medical facilities where it would be feasible and beneficial to all veterans.

Adopted by the 96th National Convention of the Veterans of Foreign Wars of the United States
held in Phoenix, Arizona, August 18-25, 1995.

Resolution No. 607

Resolution No. 603

NATIONAL HEALTH CARE IMPACT ON VA

WHEREAS, the Department of Veterans Affairs has a mission to provide health care of veterans; and

WHEREAS, VA hospitals and medical care facilities have been providing this health care for sixty years; and

WHEREAS, veterans have earned special treatment through their military service; and

WHEREAS, recently there has been introduced in Congress national health care proposals which would eliminate the veterans health care system; now, therefore

BE IT RESOLVED, by the Veterans of Foreign Wars of the United States, that should any national health care bill be enacted it not reduce or abolish the VA health care system.

**Adopted by the 96th National Convention of the Veterans of Foreign Wars of the United States
held in Phoenix, Arizona, August 18-25, 1995.**

Resolution No. 603

Resolution No. 601

REFORM OF ELIGIBILITY FOR ACCESS TO VA HEALTH CARE

WHEREAS, the existing laws governing eligibility to access VA health care are clearly illogical and virtually ensure that VA is unable to provide a full continuum of care to veteran patients, contrary to sound medical practice; and

WHEREAS, the United States Code, establishes eligibility for VA medical care and a clear statement of obligation by the government to pay for that care is conspicuously absent, a circumstance which places the Department of Veterans Affairs in the position of perpetual supplicant in the matter of obtaining funds to carry out the mandates of the law; and

WHEREAS, VA is required by law to collect payments from third-party health insurers and such collections, other than for administrative costs, do not remain within VA and are instead deposited into the General Treasury Fund; and

WHEREAS, it is our position that all honorably discharged veterans should have a mandated entitlement by law to access the full continuum of VA health care which is defined as ranging from preventive through nursing home care, and which recognizes VA as "case manager" for the full range of ancillary services as well; and

WHEREAS, we further believe that eligibility to exercise that mandated entitlement is satisfied by all veterans who are service-connected from 0 to 100 percent as well as those veterans in receipt of VA pension, and those non-service connected veterans whose lower incomes currently qualify them for limited access via "means testing"; and

WHEREAS, the remaining veterans could establish their eligibility by some form of payment option, such as third-party insurance, Medicare, out-of-pocket or even by payment of medical insurance premiums directly to VA; now, therefore

BE IT RESOLVED, by the Veterans of Foreign Wars of the United States, that the Congress enact legislation bringing order to the present chaos affecting eligibility for VA health care by providing all veterans with mandated access to the full continuum of VA health care; and

BE IT FURTHER RESOLVED, that the Congress and the Administration take appropriate action to ensure that third-party collections by VA remain with that agency and not be offset from its annual appropriation and that Medicare reimbursement to VA be authorized for care provided to veterans again without any offset from its appropriated funds; and

BE IT FURTHER RESOLVED, that specific appropriations support be established for any medical programs directed by the Congress to be provided to veterans both now and in the future.

Adopted by the 96th National Convention of the Veterans of Foreign Wars of the United States
held in Phoenix, Arizona, August 18-25, 1995.

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSES

Committee on Veterans Affairs
Hearing on October 18, 1995
Follow-up Questions for
Major General George K. Anderson, USAF, MC
Office of Assistant Secretary of Defense (Health Affairs)
from Honorable Chet Edwards
Ranking Member
Subcommittee on Hospitals and Health Care

1. a. In 1988, GAO reported that DoD facility directors had little incentive to provide services to VA because they were not permitted to retain reimbursements from sharing agreements. Under DoD guidelines set in 1989, DoD does not permit its facilities to retain dollars identified as reimbursement for military personnel cost (only operating and maintenance \$'s). As discussed at the hearing, the joint report of Sept. 1, 1995 on Nellis Federal Hospital cited "Financial Disincentives" as one of the problems contributing to underutilization of that joint-venture facility. Specifically, the report states, "DoD budgeting at the national level anticipates VA revenue from DVA-DoD sharing arrangements and offsets local budgets by the amount generated locally through these arrangements. Hence, local Air Force management derives no financial benefit from the sharing agreements."

VA facilities appear to be providers of services to DoD (vs. DoD as the provider) in approximately six out of every seven instances. Would that disparity be as great, in your view, if DoD facilities could retain all the reimbursements from their sharing agreements with VA?

Answer: Appendix B of the annual DoD/VA Sharing Report to Congress, a listing of the Total Services by Provider of Care, shows that approximately 50% of the VA provider services are for high technology or high cost areas. The data also indicates that the services most frequently utilized under sharing agreements are: Diagnostic Radiology; Pathology Services; Dental Care; Pharmacy Services; Inpatient Psychiatric Care; and Inpatient Internal Medicine Care. Most of the 144 VA facilities involved in sharing are major medical centers while in 1994 there were only 14 DoD medical centers. The remaining 126 DoD facilities are medium to small community hospitals that have limited specialty and/or high technology capability. It is clearly unrealistic to expect balance in the provision of services between VA and DoD facilities. Significantly during FY1994, our cost data shows that DoD paid VA facilities \$26.6 million and VA paid DoD facilities \$18.8 million for medical facility level services. That would suggest that even though DoD purchased more services there is more equivalency in the value of those services and that both VA and DoD have avoided significant costs through mutually beneficial sharing. There does not appear to be disparity in these sharing agreements.

b. As we discussed in an exchange at the hearing, two departments of the Federal Government have been charged to implement a law that calls for maximizing cooperative sharing between them. Yet the two are implementing differently a provision of Public Law 97-174 which specifies that "any funds received through such a reimbursement shall be credited to funds that have been allotted to the facility that provided the care of services" (codified at section 8111(e) of title 38, U.S.Code). As you acknowledged the DoD directive on reimbursements departs from the clear directive in the law. Your response to my questions on this subject indicated that the DoD directive would be changed to bring the Department's reimbursement-crediting policies into conformity with law. Please provide a status report on this matter; if such policy has not yet been changed please report when it will be changed, and provide a follow-up report to the committee when it has been changed.

Answer: The response was not meant to suggest that the DoD Directive departed from the law, rather that any misinterpretation of the DoD directive would be corrected. In that regard, the most recent Joint Follow-up Report on Nellis Federal Hospital, has recognized that the initial report had been in error when it suggested that DoD policy precluded the facility from retaining the funds or that the DoD practice was to offset the budget by any amount related to sharing reimbursement. In fact, on May 15, 1989, in accordance with PL97-194, DoD published its DoD VA/DoD Health Care Resource Sharing Reimbursement Guidelines. In accordance with those guidelines military facilities are authorized to retain all sharing related reimbursements except for those funds pertaining to military personnel. Because the facilities do not budget for military pay,

those dollars identified as reimbursements for military personnel are returned to the Services' central military appropriation account.

2. The joint report by VA and the Air Force Surgeon General on the Nellis hospital cites "limited ancillary support", including inadequacy of services including operating rooms, radiology, nuclear medicine, and intensive care, as an important factor contributing to low patient occupancy at that hospital. The report states that the Air Force had initially committed itself to a plan to provide all ancillary staffing, but that, based on a restrictive July 1991 DoD General Counsel opinion, the Air Force could not employ additional personnel to meet VA workload requirements. Among its recommendations, the report urges a reassessment of the restrictive view taken in the General Counsel opinion in light of its finding that "joint ventures will never reach their full potential if sharing of personnel and services between both agencies is severely restrictive, ... (and) must have the flexibility to meet increased workload demands by using sharing agreement revenues to hire additional staff." The DoD General Counsel opinion takes a very narrow view of a very broad statute and is highly questionable. It proceeds, for example, from a premise nowhere articulated in the law that "a sharing agreement must be mutually beneficial to the two facilities". The intent of the law, as expressed in its findings, is to reduce Government costs through cooperation between facilities of the two Departments. The scope of such cooperation is broad: sharing of "health care resources". That term could not be more broadly defined, including as it does "any ... health care service, and any health-care support or administrative resource." For the Departments to permit a joint-venture facility to be operated inefficiently on the basis of an opinion by one Department's General Counsel, an opinion which the other Department's General Counsel apparently disagrees, is inexplicable. Please reassess your position on this matter and report accordingly.

Answer: The DoD General Counsel opinion was rendered under a completely different situation that existed between a VA and military hospital in 1991. Its applicability to this situation is unclear and has to be addressed in greater detail. This topic will be formally addressed in a VA/DoD Sharing Committee meeting scheduled on December 21, 1995. A recommendation concerning the appropriate course of action will be made at that time.

3. All reports we have heard about the Asheville CHAMPUS-program sound positive, yet nearly three years after enactment of the legislation that authorized such programs all across the country DoD has only recently opened the door to the second and third VA sites, but reportedly said "no" to others which were positioned to institute programs. These programs provide good services to your beneficiaries, realize savings for DoD, don't impede moving toward TRICARE and help position VA facilities to be effective providers under TRICARE. It would appear that the Office of the Assistant Secretary objects to authorizing any additional sites. If this is not the case, please advise the Department of Veterans Affairs and the Committee; if it is, explain the objection?

Answer: The Department of Defense has no objection to VA facilities performing CHAMPUS services. In fact, the Asheville pilot program concept was agreed upon at a joint meeting of the Chairman of the Veterans Affairs Committee, the Acting Assistant Secretary of Defense (Health Affairs) and the Department of Veterans Affairs Acting Under Secretary of Health. Subsequent to implementation of the Asheville model, VA and DoD agreed that the future focus would be on VA facilities accessing TRICARE where, as subcontractors to the Managed Care Support Contractors, they can be network providers. A final list of facilities interested in CHAMPUS provider status was reviewed by DoD, in consultation with VA, and the two final facilities agreed upon. A major consideration in that decision was the recent closure of military installations at those two locations was that no residual military hospitals existed within approximately one hundred miles.

4.a. This Committee has viewed the partnership between VA and DoD as a natural one and we have encouraged it as a means of fostering efficiency and better service to both Department's beneficiaries. As I understand it, DoD refuses to consider VA facilities as the equivalent of military treatment facilities as a preferred and less costly setting for care of CHAMPUS patients. Instead, you have adopted policies which have the effect of discouraging use of VA facilities. Could you explain why this makes economic or policy sense?

Answer: DoD has actively promoted sharing relationships with VA facilities and it has not adopted policies discouraging the use of VA facilities. There exist Department to Department agreements in a number of areas, such as head injuries, where VA is the provider of choice. In TRICARE, which is the DoD model for operating its health care delivery system, the VA has the option of becoming a network provider. Some conditions that apply to other providers have been waived to facilitate VA facility access to the network. In an extremely fluid, and in many respects unknown, environment DoD has worked closely with VA to provide for VA facility participation in the military health care delivery system of the future. For the relationship to be cost effective, a facility cannot be, on the one hand, an extension of the direct care system, and on the other hand, a CHAMPUS provider. In that respect, the Departments have jointly agreed that the best positioning is a Managed Care Support Contractor network provider.

4.b. What's your view of the proposal made by Mr. Harper, one of our witnesses at this hearing, who suggested that VA facilities be deemed "DoD priority providers" (with VA as a "second-line" provider) for TRICARE purposes?

Answer: Exactly how the "DoD priority provider" status would function is not really clear. However, at this time, under TRICARE, the Managed Care Support Contractor, provides the equivalent of "second-line provider" capability. As the Managed Care Support contractor is at risk for the CHAMPUS care within the TRICARE region, deeming VA facilities with a new status within the TRICARE regions would have adverse contractual consequences. Because the Department is also learning lessons as it proceeds further into TRICARE, its plan is to keep the existing model, including VA as network providers, until it can fully evaluate the merits of alternatives.

5. Under P.L. 102-585, DoD may waive (all or part) of the otherwise applicable copayments and deductibles if a CHAMPUS beneficiary elects care through VA. Why has the Department opted not to waive or reduce such cost-sharing obligations?

Answer: The Department of Defense is achieving through TRICARE, what it has been trying to establish for several years - a congressionally mandated uniform benefit which applies to all of its beneficiaries wherever they go for care. TRICARE is a triple option plan, TRICARE Prime (Health Maintenance Organization feature), TRICARE Extra (Preferred Provider feature), and TRICARE Standard (Standard CHAMPUS feature). Each feature has an associated beneficiary cost component. By law, TRICARE must be budget neutral. Therefore, the cost to the beneficiary and the government is carefully balanced to ensure that neutrality. Eliminating or reducing beneficiary co-payments when using VA facilities would be inconsistent with that requirement.

6. The Nellis report made several recommendations for action at the headquarters level to promote more effective resource-sharing at joint venture facilities. What is the status of action on those recommendations?

Answer: All of the national level recommendations are being addressed. A joint VA/DoD working group is already in existence. Its structure and membership is being reviewed to ensure that it can provide the appropriate response to issues such as Nellis.

7. Dr. Kizer testified at this hearing that a joint venture between VA and DoD should involve an arrangement where the host facility is able to provide for the most acute or intense patient care needs. Please comment on that view; if you agree, has or will that principle lead to rethinking any of the joint venture projects that are still under development?

Answer: Dr. Kizer's view, that the joint venture host must meet the highest level of care requirements, is a new factor in planning for joint ventures and will have to be addressed in the joint study of VA/DoD health systems requested by the Vice President. If incorporated as a planning criterion, it will unquestionably influence both Departments' views on the functioning of Joint Ventures in the future.

Congressman Edwards to David P. Baine, Director, Health Care Delivery and Quality Issues, Health, Education, and Human Services Division, General Accounting Office

- 1) **Mr. Baine, you were an early proponent of VA/DOD sharing. In your view, has VA/DOD sharing achieved its full potential or could the two systems go a lot further? If further expansion appears feasible, please indicate which avenues appear most fruitful. Are there impediments or disincentives, including fiscal disincentives, that stand in the way of accomplishing more?**

VA/DOD sharing has grown substantially in recent years. The program has resulted in improved efficiency and effectiveness and has reduced some duplication of services, as the Congress intended. As to how much further they can go, there are undoubtedly un-tapped opportunities for more sharing.

The major impediment to optimal sharing today is likely to be the same cultural barrier that has been in place since the program's onset. That is, VA and DOD have different organizational cultures and still, sometimes, do not consider each other as viable alternative sources of care or as potential customers for their unused capacity.

In addition, if DOD adopted VA's policy of allowing facilities to retain all of their sharing reimbursements, DOD facility commanders would no doubt have a stronger incentive to share than they do under the current DOD policy, where the personnel portion of their sharing reimbursements reverts back to the Department.

- 2 a) **GAO issued a report last year that was critical of DoD for failing to mount more than a single pilot program under a law passed in 1992 for VA to provide care to CHAMPUS beneficiaries. Would you view the Asheville program as a money-saver for DoD?**

We have not looked closely at the Asheville agreement, but it is likely showing a savings for the CHAMPUS program because of the discount that VA is offering. However, given that VA is adding capacity to serve DOD patients, at least in the outpatient area, GAO would have to know more about the costs and benefits to VA before offering an opinion as to whether or not this is a benefit to VA or to the veterans it serves, or whether this is an overall money-saver for the government.

- b) **Doesn't the development of a program such as Asheville's have the additional advantage that it lays the foundation for VA becoming a successful partner in the future when DoD implements the TRICARE program in that area?**

CHAMPUS/VA sharing such as in Asheville does lay the foundation for VA sharing with TRICARE. The managed care support contractor will likely require compliance with billing and utilization management procedures at least equivalent to those CHAMPUS requires, and probably more. If a VA medical center has experience participating in CHAMPUS, that facility will probably be much better able to meet TRICARE requirements than one that has no such experience.

- c) **DoD has been willing to okay only 2 more such pilots. Given the success of the Asheville program, wouldn't it be advantageous to the government to expand that model in regions in which the implementation of the TRICARE program is still distant?**

The basic changes that VA needs to make in order to participate in the CHAMPUS program -- developing itemized billing systems and preparing for external utilization and quality reviews -- will be required before VA facilities can participate in either CHAMPUS or TRICARE. Accordingly, we believe VA should be moving to develop such capabilities now rather than waiting for implementation of TRICARE.

- 3) It's my understanding that under Public Law 102-585 DoD could permit its beneficiaries to use VA facilities under TRICARE free of any obligation to pay copayments or deductibles. If VA can provide care to DoD beneficiaries at lower cost than private sector providers, wouldn't it make sense to encourage patients to use VA by waiving or reducing otherwise applicable cost-sharing requirements?

Reducing patient cost sharing as an incentive to bring patients into a VA facility to make use of VA's excess capacity (at lower overall cost to CHAMPUS) would likely generate savings. However, one aspect of such an agreement that DOD would have to watch closely would be the effect of the reduced or eliminated cost sharing requirements on demand for care. It has been shown that, in the absence of managed care controls, care that is free to a patient can be overused, thus driving up overall costs. GAO does not know if that would be the case with a financial incentive for DOD patients to use VA facilities.

Also, VA does not have reliable data on its costs for providing hospital care. Waiving cost-sharing requirements for CHAMPUS beneficiaries would, therefore, increase the risk that funds appropriated for the care of veterans might instead be used to subsidize care for CHAMPUS beneficiaries.

Committee on Veterans Affairs
Hearing on October 18, 1995
Response to Follow-up Questions for
James A. Christian
Director, VAMC, Asheville, NC
from Honorable Chet Edwards
Ranking Member
Subcommittee on Hospitals and Health Care

1. You've been a long-time proponent of VA-DoD sharing and a successful innovator under the legislation we developed in the 102nd Congress. Yours, however, is the only VA facility actively implementing a sharing authority Congress enacted in 1992. To your knowledge how many other VA facilities were prepared, or were actively preparing, to launch similar programs? What happened? Given the success of your program, would it still make sense to start up additional programs at interested VA sites in proximity to a large CHAMPUS population?

Thank you for your compliment on the innovative sharing we have at Asheville. Unfortunately, our facility is the only VA medical center that is operational under this pilot program although two others have recently been approved to begin. Almost all VA medical centers would like to be authorized as CHAMPUS providers. The Medical Sharing Office in VA Headquarters reports that many medical centers are interested in participating in the CHAMPUS program. It is my opinion that DoD/Health Affairs was reluctant to begin a large scale expansion of our CHAMPUS model because they were moving to, or had in place, managed care support contracts in their various regions. They preferred to work VA relationships and sharing into this contract system. VA would have to compete as a provider just like all other private sector providers. Such a policy decision would seem to defy prior sharing legislative intent.

It is my opinion that our pilot could and should be implemented in other VA medical centers as soon as possible. All the medical centers in our VISN are extremely interested in becoming CHAMPUS providers. The primary reason I believe we should implement immediately, with full resolve and purpose, is that our model allows for caring for CHAMPUS beneficiaries in the standard, traditional way. DoD is not abandoning this option for beneficiaries in any region, even under the managed care support contracts. So why not begin immediately with all VAMC's that are interested? As DoD phases in the managed care option, beneficiaries could consider changing, and VA can participate with DoD in that option as well. However, the standard option will remain regardless.

2. From your experience, what costs or difficulties does DoD incur in expanding the number of "Asheville-model" VA sites?

Most of the costs related to expanding the number of sites will be incurred by the participating VA medical centers rather than DoD. We have been required to produce itemized bills for the services provided to CHAMPUS beneficiaries; however, the VA's current billing system is able to accommodate only per diem billing. When our pilot was implemented the CHAMPUS claims contractor had to make a few system changes in order to process our claims. These changes were paid for by DoD. As DoD moves toward managed care support contracts, it is anticipated that costs associated with VA participation under these contracts will decline for both DoD and VA. In order to participate in the managed care program, the managed care contractor will require the VA medical center to satisfy the contractor's requirements with few or no changes to the contractor's current processes and procedures. The VA is developing the expertise and tools that will enable them to satisfy these obligations. Any difficulties DoD may have incurred in the past in expanding the CHAMPUS program will be minimized under a managed care support contract. The contractor will be responsible for the operation of the program on behalf of DoD and will view the VA as just one of many contracted providers.

A VA medical center implements a CHAMPUS program based on space availability and excess capacity. Initially resources are redirected rather than expended. The revenue generated from the program covers ongoing operational costs and provides additional resources for expanding services to veterans. The training associated with learning the new skills required to provide and bill for services rendered to a non-veteran population will continue to be an expense at each VA medical center. The expenses incurred with implementation will primarily be start-up costs similar to those associated with any new project and will be recouped through insurance revenue.

