STATEMENT OF
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NATIONAL LEGISLATIVE COMMISSION
THE AMERICAN LEGION
TO THE
PRESIDENTIAL TASK FORCE TO IMPROVE HEALTH CARE DELIVERY TO OUR NATION'S VETERANS
ON
HEALTH CARE DELIVERY TO AMERICA'S VETERANS

JANUARY 15, 2002

Dr. Wilensky and Task Force Members:

The American Legion appreciates the opportunity to provide testimony on the Presidential Task Force to Improve Health Care Delivery to Our Nation's Veterans. America's obligation to the men and women of the armed forces – past, present, and future -- must never be taken lightly. The charter of this Task Force is very clear. Today, The American Legion will provide you a succinct listing of recommendations its 2.8 million members believe this Task Force should seriously consider to improve health care delivery to the 24 million veterans, especially those veterans with medical conditions as a result of honorable military service.

On Memorial Day 2001, President Bush established this Federal advisory committee "in order to provide prompt and efficient access to consistently high quality health care for veterans." Initially, this task force's mission had three major components:

1. identify ways to improve veterans' benefits and services through better coordination of the two departments;
2. review barriers and challenges that impede coordination and identify opportunities to improve business practices to ensure high quality and cost effective health care; and;
3. identify opportunities for improved resource utilization between VA and DoD to maximize the use of resources.

The American Legion supports these goals. There are already several joint venture models in the field, in which local personnel have been able to negotiate based on the healthcare demands in their areas. They have had to assess resources and obstacles and identify issues that can cause problems, such as inability to access electronic data systems, leadership and staff "buy-in" and variations in patient populations served (younger active duty versus aging veterans population). However, it seems that in areas where VA and DoD have first made the decision and commitment to work together, issues and obstacles are negotiated and resolved. Joint ventures occur based on opportunity and benefit or they make sense and save dollars. Interestingly enough, these

joint ventures have come about by shear ingenuity and creativity of the personnel in the prospective agencies, since there are no federal guidelines in place to determine how these agreements should work.

In previous meetings, the Task Force received briefings from both the Departments of Veterans Affairs (VA) and Defense (DoD). Both the Military Health System (MHS) and the Veterans Health Administration (VHA) provided you with detailed briefing books profiling their unique health care delivery systems. There are many similarities:

- Receives annual discretionary Federal appropriations – therefore, neither is formally recognized as an entitlement like Medicare or Social Security.
- Bills, collects, and retains third-party reimbursements; however, only MHS participates in Medicare subvention.
- Earns access to the health care delivery system as a result of honorable military service; however, all patients do not receive the same health benefit coverage.
- Provides access to care on a priority basis.
- Provides both inpatient and outpatient health care.
- Provides some patients health care services at no cost, while other patients must pay for access and health care services.
- Provides pharmacy services.
- Provides medical education and research.
- Experiencing information technology problem.

There are also many noticeable differences:

- MHS provides limited lifetime family health care services, but VHA is not focused on family health care services.
- MHS contracts the majority of its health care services from TRICARE Contractors, for-profit health care networks. VHA contracts some of its health care services, primarily long-term care.
- MHS maintains a global health care mission, whereas VHA's mission is not global.
- VHA physical infrastructure, within the United States, is more than twice the size of MHS.
- VHA provides more specialized health care services than MHS, especially long-term care.

The Military Health System

MHS's primary mission is to support combat forces in war. In peacetime, MHS's primary mission is to maintain and sustain the well being of the fighting force in preparation for war. Active-duty service members have top priority to health care at no personal cost. Reservists and National Guard members only become a priority when Federalized or on active-duty for training. Health care services for military retirees and dependents are clearly a secondary mission regulated to TRICARE.

TRICARE was designed to replace the Civilian Health and Medical Program of the United States (CHAMPUS). The major feature of TRICARE is the triple option:

1. **Prime** – HMO type program – made up of Military Treatment Facilities (MTF) and civilian primary care facilities. Enrollees will obtain most of their care within the network, both military and civilian, and **pay** substantially reduced cost shares when they receive care form civilian network providers. Active-duty service members will normally receive their care in a MTF.
2. **Extra** – preferred providers network on a case-by-case basis – obtain care in the network with a resulting reduction in co-payments.
3. **Standard** – non-network providers – similar to CHAMPUS. Receives care from non-network providers with the resulting payments of cost shares and deductibles.

All MHS beneficiaries continue to be eligible to receive care in a MTF, but active-duty service members remain the first priority. Active-duty family members and retiree families, who enroll in TRICARE Prime, will have priority over other non-enrolled TRICARE beneficiaries.

TRICARE For Life extends TRICARE coverage to all entitled persons age 65 and over who would otherwise have lost their TRICARE eligibility due to attainment of Medicare eligibility. In order for these individuals to retain their TRICARE eligibility, they must be enrolled in the supplementary medical insurance program under Part B Medicare. In the case of medical or dental care provided to these individuals for which payment may be made under both Medicare and TRICARE, Medicare is the primary payer and TRICARE will normally pay the actual out-of-pocket costs incurred by the patient.

The Veterans Health Administration

VHA's primary mission is to serve the medical needs of America's veterans. This is accomplished by providing specialized care, primary care, and related medical and social support services for eligible veterans. With enactment of the Eligibility Reform Act, Public Law 104-262, VHA is opened to all veterans; however, like MHS, access to VHA health care is on a priority basis:

- **Priority Group 1**: Veterans with service-connected disabilities rated 50 percent or more disabling.
- **Priority Group 2**: Veterans with service-connected disabilities rated 30 percent or 40 percent disabling.
- **Priority Group 3**:
  - Veterans who are former POWs.
  - Veterans awarded the Purple Heart.
  - Veterans whose discharge was for a disability that was incurred or aggravated in the line of duty.
  - Veterans with service-connected disabilities rated 10 percent or 20 percent disabling.
  - Veterans awarded special eligibility classification under Title 38, USC, Section 1151, "benefits for individuals disabled by treatment or vocational rehabilitation."
- **Priority Group 4**:
  - Veterans who are receiving aid and assistance or housebound benefits.

- ♦ Veterans who have been determined by VA to be catastrophically disabled.

- **Priority Group 5**:
  - ♦ Nonservice-connected veterans and service-connected veterans rated 0 percent whose annual income and net worth are below the established dollar threshold.
  - ♦ Veterans receiving VA pensions benefits.
  - ♦ Veterans eligible for Medicaid benefits.
- **Priority Group 6**:
  - ♦ World War I veterans.
  - ♦ Mexican Border War veterans.
  - ♦ Veterans solely seeking care for disorders associated with:
    - Exposure to herbicides while serving in Vietnam; or
    - Exposure to ionizing radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki; or
    - For disorders associated with service in the Gulf War; or
    - For any illness associated with service in combat in a war after the Gulf War or during a period of hostility after November 11, 1998.
  - ♦ Compensable 0 percent service-connected veterans with income and net worth above the statutory threshold.
- **Priority Group 7**:
  - ♦ Veterans with income and net worth above the statutory threshold who agree to pay specified co-payments
    - Subpriority a: noncompensable 0 percent service-connected veterans, and
    - Subpriority c: all other Priority Group 7 veterans.

VHA is America's largest, integrated health care delivery system consisting of hospitals, ambulatory clinics, nursing homes, domiciliaries, and readjustments counseling centers. VHA is the nation's largest trainer of health care professions. Through its affiliation with medical schools, academic medial centers, and other research institutions, VHA continues to be a major national research asset for conducting basic, clinical, epidemiological and behavioral studies across the entire spectrum of scientific disciplines. Yet, many Americans forget that VHA serves as a contingency backup to MHS and supports the National Disaster Medical System.

Working Together

With the advent of the first joint venture and the emergence of VHA and MHS sharing agreements, The American Legion had the foresight in May 1989 to establish its own Special Task Force on Veterans' Medical Care to review the effectiveness of these cooperative efforts. The initial Task Force report of September 1989 to the National Executive Committee stated that the sharing agreements, "represented positive adjuncts to efforts to meet the mission of medical centers. These joint ventures enhance the availability and variety of services provided to veterans and can provide avenues to increase joint education and research endeavors." The report also cautioned, "adequate funding must be provided to both agencies in order for each to sufficiently treat their

primary beneficiaries. Sharing agreements in and of themselves are not the answer to improving the decremental VA and DoD funding."

Currently, VHA and MHS sharing occurs among 165 VAMCs and most military medical treatment facilities. VA and the military have agreed to share 7,963 services covering a broad range of hospital related activities. Both Departments are exploring ways to improve coordination of service delivery in such areas as long-term care, pharmacy, chiropractic services, and joint ventures.

There are seven joint venture sites where VHA and MHS are co-located on the same campus:

- VA New Mexico HCS & Kirtland AFB (Albuquerque)
- El Paso VAHCS & William Beaumont Army Medical Center (Texas)
- VA Key West & Navy (Florida)
- VANCHCS & Travis/Mather AFB (California)
- Tripler Army Medical Center & VAMROC Honolulu (Hawaii)
- Nellis AFB & Southern Nevada VAHCS (Las Vegas)
- Elmendorf AFB & VAMROC Anchorage (Alaska)

Many significant changes have occurred in the ensuing years. VA health care has been restructured into 22 Veterans Integrated Service Networks (VISNs) with an emphasis on outpatient services and the location of services closer to veteran users. The Veterans Health Administration (VHA) now has nearly 1,000 outpatient clinics in addition to its 172 VA Medical Centers (VAMCs). Congressional legislation reformed VA's eligibility criteria, which led to an enrollment system opened to all veterans, within existing appropriations; however, care is still delivered on a priority basis. VA expanded its preventive services and developed a uniform medical benefits package.

Meanwhile, the military health care system was undergoing its own transition. In the 1990's MHS took a bold step in its effort to curtail skyrocketing CHAMPUS costs, by creating TRICARE. TRICARE offered MHS health care beneficiaries the choice of three health care options: fee-for-service, preferred provider, or health maintenance organization. TRICARE consists of 11 independent regions operated by for-profit contractors. Although DoD has health care liaisons working with each contractor, the contractor controls health care delivery and reimbursement activities. Another major impact on MHS was the loss of nearly half of its MTF due to the Base Realignment and Closure Commission (BRAC).

During this period, VA and DoD continued to look for opportunities to coordinate health care delivery to patient populations. Several successful joint ventures were established. In the same spirit of cooperation, over 130 VHA medical facilities became subcontractors for TRICARE services and sharing agreements increased, although to a relatively limited extent.

Last Congress, major legislation was enacted granting TRICARE for Life and expanding greater access to all DoD pharmacy benefits for TRICARE Medicare-eligible military

retirees and their Medicare-eligible dependents. Meanwhile, the Veterans Millennium Health Care Act (PL 106-117) mandated VA and DoD enter into an agreement to reimburse VA for the cost of providing care to enrolled, Priority 7 retired service members.

VA and DoD are drafting instructions to improve billing and collections; especially regarding money owed VA Medical Centers as a result of DoD's converting supplemental care money to TRICARE. The amount of money generated from providing services to TRICARE beneficiaries through January 2001 (FY 2001) was $2,985,784, an increase of $1,420,969 from FY 2000. This represents a 90.8% increase from the previous year period and reflects the additional reimbursements earned from increased joint sharing services.

In his FY 2002 budget request, President Bush recommended that any veteran eligible for both VHA and TRICARE enrollment must choose one or the other health care system, but not both. Furthermore, the president recommended the transfer of $235 million from VHA medical care to DoD medical care because of the estimated number of military retirees currently enrolled in VHA who would choose TRICARE. The American Legion adamantly opposes both recommendations for several very cogent reasons:

- VHA currently is not a family health care plan;
- Veterans with service-connected medical conditions may need the specialized services provided by VHA;
- VHA offers other specialized services not available under TRICARE – long-term care, blind rehab, and spinal cord injury;
- All veterans are eligible to enroll in VHA due to their honorable military service – this is an earned benefit;
- When TRICARE was created and Medicare-eligible military retirees could not enroll in TRICARE, no similar transfer of health care dollars was made from DoD medical care to VHA medical care; and
- Military retirement is not a criterion for health care in the VHA; therefore, this unique patient population is not a factor in the calculation of annual discretionary appropriations.

In May 2000, GAO issued a report, *VA and Defense Health Care,* in which GAO recommended these Federal agencies and Congress develop policies that would standardize pricing guidelines and referral procedures. GAO believes the current ad hoc approach to developing joint ventures is too dependent on local personalities and commitments; therefore, changes in staffing patterns could easily upset the stability of the organizations. However, when The American Legion conducted its site visits, both VA and military personnel felt that the sharing agreements and joint ventures were able to work precisely because there was little involvement from the Federal agencies at the national level. At the local level, they were able to let demand drive the negotiations without having to acquiesce to bureaucratic considerations. None of the professional staff at any of the locations The American Legion visited advocated for Washington-based guidance or oversight. It seems they are doing fine on their own. However, best

practice awareness could be shared with other VHA and DoD medical facilities that might want to consider more cooperative efforts.

In reviewing the cooperative efforts between VHA and MHS, The American Legion identified several different ways in which VHA and MHS could cooperate:

- buy or sell services between the Federal agencies. VHA facilities are authorized to make maximum effective use of their resources and can provide services to community entities when there is no diminution of services to veterans. All revenue generated from the sale of services is used to enhance care for eligible veterans. During 2000, there were 1,136 new contracts for resources purchased ($289,712,000) and provided ($32,090,000) totaling $321,802,000. This is a significant increase in activity from past years in resources purchased. The expanded authority gives VHA the mechanism to make the best use of available resources to purchase services in the most cost-effective manner.
- share staff, such as having reservists drill at VHA hospitals, especially since VHA is affiliated with many medical schools.
- share technology and other equipment. A mammography machine, which might not be a justifiable cost for one, can become beneficial if bought jointly as in Albuquerque.
- conduct joint education and training. VHA is affiliated with 103 medical schools.
- co-purchase pharmaceuticals and medical/surgical supplies. VHA and MHS can share supplies and borrow pharmaceuticals from each other in emergency situations.
- VHA can increase its role as a TRICARE sub-contractor.
- patient medical records and other information can be jointly accessed to enable service members a smoother transition from active duty.

With the start up of the hospital at Elmendorf AFB, all of the planned joint ventures are on line. Unfortunately, no new joint venture initiatives have emerged in the past several years, yet demand for services continues to increase. At this time, it is difficult to conclude why there are not more joint venture sites. This could be attributed to the lack of construction dollars and other resources required to bring a facility up to code. Yet leadership at both VHA and MHS appear to be motivated to institute new joint ventures. It would seem an opportune time for MHS to co-locate TRICARE providers at VHA facilities or have VHA primary care clinics on more military installations.

The American Legion recognized the importance for both agencies to maximize resources during a visit to northern California in April 1998. The American Legion sent its Task Force to northern California to investigate VISN #21. VA had recently adapted the Veterans Equitable Resource Allocation (VERA) methodology and The American Legion wanted to ensure that veterans were being provided equal access to care under this new formula. Coinciding with this time period, VISN #21 released a report completed by Price Waterhouse, *Assessment of Veterans' Health Care Needs in Northern California*, which addressed the future of a VHA hospital at the David Grant Medical Center located on Travis Air Force Base. Legionnaires were outraged by this report since

it called for a two-year clinic construction project. They did not want to wait another two years before having a VHA primary care clinic in the Solano County area.

The American Legion Task Force met with VHA and Air Force officials to discuss the potential of resolving this issue sooner. The American Legion discovered that the Air Force would benefit from having space availability at the VHA facility at Mare Island. Due to downsizing, the military would have excess capacity at David Grant Medical Center. Six months later, VHA and MHS were able to reach an agreement that would allow VHA to open a primary care clinic at David Grant Medical Center and VHA was able to accommodate the Air Force's needs at Mare Island. This has satisfied both beneficiaries with access to quality care. The only remaining problem for veterans (who are not retirees) going to the VHA clinic at Travis is getting through the guard gate without a military identification card.

The American Legion is continuing to evaluate the current VHA and MHS sharing initiatives. The American Legion's Task Force members are receiving VHA and MHS briefings and conducting site visits. The American Legion plans to delineate and assess the strengths, weaknesses and potential of VHA and MHS initiatives. The goal of this extensive review of the VHA and MHS healthcare systems is to praise what works, identify what needs to be corrected, and recommend new possibilities.

In May 2001, The American Legion visited 3 joint ventures (Michael O'Callahan Federal Hospital, Las Vegas, NV, William Beaumont Army Medical Center, El Paso, TX and Kirtland Air Force Base, Albuquerque, NM) in an attempt to better understand the implications and intricacies of VHA and MHS sharing. In general, The American Legion received positive feedback about the opportunities and results of the sharing agreements. There is a clear indication of benefits for both systems. For example, in El Paso, Beaumont MTF provides access to hospitalization for veterans in a cost-effective manner that otherwise would not be available in that part of Texas.

In Las Vegas, veterans expect the full continuum of care commensurate with a tertiary facility. From its inception, Callaghan was not designed nor envisioned for that role. Consequently, veterans were often sent to southern California for complex services. VHA has made a significant attempt to provide services locally, which has included the purchase of services in the community and from Nellis AFB. Services have been gradually enhanced at Callaghan. VHA currently has an identified need for additional operating room time.

In Albuquerque, the Air Force initially had a presence at the VAMC. They had dedicated beds and jointly staffed the emergency room. Due to the downsizing of the base, the Air Force was no longer able to sustain these operations. All they had was their own out patient and dental clinics. The Air Force was able to purchase inpatient services and ancillary support from VHA and is now better able to provide care to their active duty, dependents and retirees. However, there is a key issue in Albuquerque regarding the new TRICARE for Life benefit. This is the only joint venture where VHA, instead of MHS, is host. Therefore, it is the only joint venture where MHS pays VHA. TRICARE for

Life will complicate this arrangement because VHA cannot receive funds from Medicare. Retirees who DoD currently can send down the hall to use VHA lab and ancillary services will have to be sent into the community to get those services. This will result in a significant impact for retirees and their dependents in this area, as well as, for the joint venture as a seamless system.

The American Legion believes this was overlooked due to the unique nature of this particular joint venture. The VHA director and the base commander reported this problem to members of the congressional Veterans' Affairs Committee that visited their site prior to The American Legion visit. Both local VHA and MHS officials requested that Congress grant a waiver that would allow VHA to collect the Medicare payments for those retirees and their dependents treated under the TRICARE for Life provision. The American Legion urges that this Medicare waiver be granted before the October inception of TRICARE for Life, so as not to interrupt retirees' access to health care.

Through its investigation of the VA and DoD sharing issue The American Legion has made several observations:

- VHA and MHS are the largest federal health care providers in this country. In FY 2001, VHA medical care had a $20.7 billion budget. VA has 172 medical centers 900 ambulatory clinics, 134 nursing homes, 40 domicilaries, 72 comprehensive home-care programs, and 206 counseling centers. In FY 2001, MHS had a $18.2 billion budget. MHS has 15 medical centers, 66 community hospitals, and 489 clinics. Combined, the two agencies have 12 million enrolled beneficiaries. Clearly, there are multiple venues for sharing. The American Legion recognizes the current benefits from these sharing agreements and the potential gains from additional efforts. Sharing agreements augment services and build on the respective strengths of the participants.
- the reimbursement procedures between VHA and MHS medical systems need to be addressed. TRICARE contractors report that there are significant problems in the way VHA handles billing. VHA's automated billing technology is not compatible with the TRICARE contractors. When VHA generates a bill for TRICARE, there are approximately 90 fields to be filled in. If any of those fields are filled in incorrectly, the bill gets sent back to VHA. If there are five errors on a form, the bill will get sent back five times, because the computer will only pick up one error at a time. The bill is automatically returned for that one item to be corrected, before the remainder of the bill is reviewed. Therefore, billing takes VHA approximately 180 days to get be paid, whereas reimbursement takes the private sector 7 to 9 days.

- information systems are not integrated. Management of the record, clinical services, coding and billing are not integrated. Last year, only $5.5 million was billed and only 7 facilities were billed greater than $500,000. Billing needs to be better integrated into hospital management and clerks need to be better trained in how to do coding. An EDI system would vastly improve VHA's medical care cost recovery operations and its relationship with its payers or it should consider contracting out the entire operation.

In addition, The American Legion realizes that sharing does not necessarily resolve partners' problems. In New Mexico, VA was not able to rely on the Air Force to help resolve its serious nursing shortage because MHS has downsized and has less authorized nursing positions. Dental service at VA receives support from Kirtland's dental clinic, but is not a source for resolving VHA's increase in waiting times. Partners entering into the joint venture need to be able to share their strengths for the partnership to be mutually beneficial.

Although, The American Legion believes that VHA and MHS cooperation is an efficient manner to dispense quality medical care and patients seem satisfied with being able to maximize their benefits, it cautions the departments to ensure a user-friendly environment, especially for the elderly and psychiatric population. Comments made by veterans in American Legion led focus groups confirmed their satisfaction with having greater access to care and felt that having the military involved provided them with more courteous service. The only complaint veterans and retirees seemed to have been regarding information dissemination. They described the difficulty in understanding all the different health care benefits (Medicare, TRICARE and VA) and how to decide which is best for them. One veteran said, "They give us five-dollar explanations, but we need fifty-cent words."

Pharmaceuticals and medical/surgical supplies seem to be an area that will need further investigation as more and more sharing opportunities are considered. To date, VHA and MHS have established 44 joint sharing contracts for pharmaceuticals. As a result of these contracts, the total estimated cost savings for both Departments was $70 million. It is difficult to project how much additional savings will be achieved due to the dynamics of the pharmaceutical market. It should be noted, however, that VA alone will accrue an estimated $745.7 million in cost avoidance, i.e. cost avoided through contract prices lower than the Federal Ceiling Price, for the period 1996 through 2002. The American Legion recognizes the cost savings realized through VHA and MHS joint sharing contracts for pharmaceuticals and supports the consideration of additional contracts.

Medicare Subvention

The American Legion strongly supports Medicare subvention for VHA. Section 1710, Title 38, USC, provides a specific listing of those veterans eligible for enrollment in VHA. This section clearly defines which veterans are entitled to hospital care and medical services. This section also identifies which veterans are eligible to hospital care and medical services. Medicare is not listed as a criterion for neither entitlement nor eligibility to VHA hospital care or medical services.

Section 1729, Title 38, USC, addresses recovery of the cost of certain hospital care and medical services. This section discusses direct billing of certain veterans and authorizes the billing of third-party insurers, to include Medicare supplemental insurers; however, exempts Medicare.

Of America's 24 million veterans, about 10 million are Medicare-eligible. Currently, VHA must bill Medicare-eligible veterans in Priority Group 7 for hospital care and medical services normally covered by Medicare – and bill any third-party insurer as well. Reimbursements received by Part B Medicare supplemental insurers are based on a percentage of the cost Medicare would have paid. This creates a disincentive for Medicare-eligible veterans to seek health care in VHA facilities.

The American Legion believes Medicare subvention would prove to be mutually beneficial to both the Center for Medicare and Medicaid Services (CMS) and VHA. The American Legion recommends that Section 1729, Title 38, USC be amended to allow VHA to bill Medicare for the treatment of nonservice-connected conditions of Medicare-eligible veterans in Priority Group 7. The American Legion further recommends allowing Medicare-eligible veterans to exercise their Medicare health care options, either fee-for-service or Medicare+Choice.

Fee-for-service would allow Medicare-eligible veterans in Priority Group 7 to use the VHA like any other health care provider. VHA would use the Medicare reimbursement rates for hospital care and medical services for only nonservice-connected medical conditions normally covered by Medicare.

Medicare+Choice would help VHA to be more compatible with MHS's new TRICARE For Life, especially in joint venture locations.

A Paradigm Shift

As DoD renegotiates contracts with the current 5 TRICARE networks, The American Legion wonders what DoD's "Plan B" might be should negotiations become stymied. The American Legion asks the question "Could VHA assume the role of a primary contractor for a TRICARE Region?" The American Legion believes VHA could assume this new mission, if required. Such a dramatic paradigm shift would go a long way in reducing costs for all three Federal agencies (DoD, VA, and CMS) and would provide consistent, coordinated quality health care for the entire patient population. The American Legion believes this would be the ultimate joint venture. VHA and MHS would then be forced to work in close harmony in all health care delivery venues among the Federal agencies without obfuscating their unique missions.

Due to VHA's primary mission to serve as the backup to the MHS during periods of national emergency, VHA is aware of the limitations in the nature of dealing with the active duty. When MHS doctors and other medical personnel get called up for rotations and deployments, VHA is prepared to step in to fill the void. As the nation's largest single health care provider, VHA has the flexibility to expand or contract its network to meet the demands placed on the system. Because of its affiliation with over 100 medical schools and research facilities, VHA has a working relationship with an array of private and public health care providers.

Conclusion

In conclusion, The American Legion is very impressed with the joint venture sites it has visited and other sharing arrangements it has reviewed. The American Legion encourages VHA and MHS to continue to explore more avenues for cooperation and to assist other areas of the country in formulating and negotiating these opportunities. The American Legion believes there are many more of these opportunities out there to be developed. The American Legion believes that the number and types of sharing agreements as indicated by the amount of dollars exchanged is minor, relative to the overall budgets for each Federal agency. The American Legion strongly recommends Medicare subvention for VHA. Finally, The American Legion believes VHA could assume a greater role in TRICARE, if required. The American Legion envisions a future for federal health care that will allow each of the unique missions of the different departments to be enhanced by a closer relationship and more mutual support.

Dr. Wilensky and Task Force Members, this concludes The American Legion's written statement.