STATEMENT OF
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NATIONAL LEGISLATIVE COMMISSION
THE AMERICAN LEGION
BEFORE A JOINT HEARING OF THE
VETERANS' AFFAIRS SUBCOMMITTEE ON HEALTH
AND
ARMED SERVICES SUBCOMMITTEE ON MILITARY PERSONNEL
U.S. HOUSE OF REPRESENTATIVES
ON
VA-DOD HEALTH CARE SHARING

MARCH 7, 2002

Mr. Chairmen and Members of these Subcommittees:

The American Legion welcomes the opportunity to provide testimony regarding the Department of Veterans Affairs (VA) and Department of Defense (DoD) health care sharing. The American Legion applauds the efforts of these committees to hold a joint hearing on such an important issue.

Access to both VA's and DoD's integrated health care system is an earned benefit from a grateful nation based on military service. Although there are many dual-eligible veterans, VA's and DoD's integrated health care system have unique mission with some degree of overlap. For this reason, The American Legion adamantly supports maintaining each independent integrated health care system, while seeking opportunities for joint ventures, resource sharing opportunities, and other areas of cooperation.

DoD's primary mission is providing quality health care to maintain military readiness. VA's primary mission is providing quality health care for America's veterans, especially those with service-connected disabilities. DoD's patient population includes a significant number of spouses and children. VA's patient population includes a very limited number of spouses and children. VA offers an array of specialized services, such as blind rehabilitation, long-term care, spinal cord and brain injury, and others. DoD offers few specialized services. Therefore, it would be unwise to ask any military retiree to choose between the enrollment in one integrated health care system or the other. However, these distinct diversities also offer ample health care sharing opportunities.

With the advent of the first joint venture and the emergence of VA and DoD medical sharing agreements, The American Legion established its own Special Task Force on Veterans' Medical Care to review the effectiveness of these cooperative efforts. The Task Force's initial report of September 1989 stated that the sharing agreements, "represented positive adjuncts to efforts to meet the mission of medical centers. They enhance the availability and variety of services provided to veterans, and they can provide avenues to increase joint education and research

endeavors." The American Legion continues to believe in and support these efforts. The American Legion recognizes the current benefits from these sharing agreements and the potential gains from additional efforts. Sharing agreements augment services and build on the respective strengths of the participants.

VA and DoD medical systems are the largest federal health care providers in this country. In Fiscal Year (FY) 2001, Veterans Health Administration (VHA) had a $20.7 billion medical care budget. VA has 172 medical centers, 900 ambulatory clinics, 134 nursing homes, 40 domiciliaries, 72 comprehensive home-care programs, and 206 counseling centers. In FY 2001, DoD had a $18.2 billion medical care budget. DoD has 15 medical centers, 66 Community Hospitals, and 489 clinics. Combined, the two agencies have 14 million enrolled beneficiaries. Clearly, there are many opportunities for sharing.

Currently, VA and DoD sharing occurs among 165 VA Medical Centers (VAMC) with most military medical treatment facilities and 156 Reserve units around the country. VA and the military have agreed to share 6,602 services covering a broad range of hospital related activities. However, this represents a decrease of over 1000 services shared from the year 2000. One of the problems cited is DoD's TRICARE managed care contract structure does not promote the use of government agency resource sharing. Both Departments are exploring ways to improve and increase coordination of service delivery in many areas such as long-term care, pharmacy, chiropractic services, and joint ventures.

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

- VA New Mexico Health Care System (HCS) & Kirkland AFB (Albuquerque, NM)
- El Paso VAHCS & William Beaumont Army Medical Center (El Paso, TX)
- VA Key West & Navy (Key West, FL)
- VANCHCS & Travis/Mather AFB (Fairfield, CA)
- Tripler Army Medical Center & VAMROC Honolulu (Honolulu, HI)
- Nellis AFB & Southern Nevada VAHCS (Las Vegas, NV)
- Elmendorf AFB & VAMROC Anchorage (Anchorage, AK)

With the start up of the hospital at Elmendorf AFB, all of the planned joint ventures are on line. Unfortunately, no other new joint venture initiatives have emerged in the past several years, yet demand for services continues to increase. This may be attributed to the lack of construction dollars and other resources required to bring a facility up to code. Yet leadership at both VA and DoD appear to be motivated to institute new joint ventures. It would seem an opportune time for DoD to co-locate TRICARE providers at VHA facilities or have VHA primary care clinics on more military installations.

Existing Barriers

Both VHA and DoD have explored joint ventures with measured success. Clearly, there are barriers – some are tangible, but most appear more philosophical or cultural. Strong management at the local level can readily identify tangible barriers and offer creative solutions, but overcoming philosophical or cultural barriers will require focused leadership. Faced with the prospects of yet another round of the base realignment and closure (BRAC) recommendations,

DoD stands to lose additional military health facilities from its inventory. Since the first BRAC, DoD has lost over 50 percent of its military hospitals. VA is currently undergoing its own version of BRAC, the Capital Asset Realignment for Enhanced Services (CARES). Each Department would be well advised to remain vigilant for the opportunity to enter into joint ventures. Neither downsizing program seems to give serious consideration to the adverse impact on the health care delivery of the veterans' community as a whole.

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

Another common physical barrier between VA and DoD is the information technology communication gap. The information technology disconnect between Departments severely restricts seamless transmission of critical information. Current technology exists to establish and maintain electronic medical records capable of storing all data collected in a Federal health care facility. This would help expedite VA's claim and adjudication process by making military medical records immediately available to provide documentation of service-connected injuries or medical conditions.

Another information technology function commonly found throughout the health care industry is the billing and collection of third-party reimbursements. Yet, this fundamental process between VA and DoD, especially its for-profit health care contractors – TRICARE – is extremely problematic. Electronic billing and collection are routine transactions between health care provider and health insurance payers. VA's ability to properly bill and collect from third-party insurers continues to lag behind the Federal discretionary budgetary expectations. This revenue shortfall adversely impacts on VA's health care delivery capabilities and limits the cooperative opportunities for TRICARE's subcontracting options as well.

Currently, VHA is directed to bill and collect third-party reimbursements for the treatment and services provided to all veterans for nonservice-connected medical conditions. In VA, the enrollment of Priority Group 7 veterans is contingent on their ability to pay for treatment and services received. However, if the Priority Group 7 veteran is Medicare-eligible, VHA is not authorized to bill Centers for Medicare and Medicaid Services (CMS) for the treatment of nonservice-connected medical conditions, even if the condition is normally covered by Medicare. The veteran is required to pay the co-payment. Any other third-party insurance coverage, including the Medicare supplemental insurer, will also be billed. In essence, VHA subsidizes CMS.

The annual VA medical care discretionary appropriations are offset by the projected collections from such third-party insurers, yet no funding credit is awarded for the treatment of enrolled Priority Group 7, Medicare-eligible veterans treated for nonservice-connected conditions. In a joint venture facility, under the new TRICARE for Life provision, this creates internal billing problems for Medicare-eligible military retirees referred to VA by TRICARE providers. Under

the conditions of TRICARE for Life, the enrolled Medicare-eligible patient must purchase the Part B supplemental coverage. TRICARE subcontractor must bill Medicare, then the Medigap insurer, and finally DoD for any remaining charges. If VA is a subcontractor for TIRCARE and cannot bill Medicare; DoD has a disincentive to send Medicare-eligible patients to VA facilities because of the additional cost to DoD.

Access to VA and DoD health care is an earned benefit based on honorable military service – not age. Medicare coverage is based on a totally different set of criteria. Both Medicare options (fee-for-service and Medicare+Choice) could be effectively administrated within VA. Using Medicare's own performance standards for the treatment of certain health care conditions, VHA has repeatedly exceeded Medicare's expectations.

Most successful sharing agreements between VA and DoD have been reached at the local level due to budgetary necessity. The key elements are quality communication and coordinated strategic planning. The principal objective is delivery of quality health care rather than pride of ownership. Maximum utilization of available federal resources should be an element in annual individual performance evaluations. Positive reinforcement should be awarded for stellar performance. Again, with the real prospect of another BRAC coupled with impending CARES recommendations, both Departments should seek sharing agreements to maximize available health services for their patient populations. American Legion representatives have visited several joint venture campuses. Each joint venture has its own strength and weaknesses, but their ultimate goal is the same – delivery of quality health care to its beneficiaries.

Cooperation

A commonly identified opportunity for closer VA and DoD cooperation is joint purchasing ventures for pharmaceuticals, medical supplies, and equipment. Utilizing economy of scales would enhance the buying power of scarce Federal discretionary dollars. Joint partnerships for contracting of pharmaceuticals have met with very agreeable results. VA and DoD have 55 national contracts and three Blanket Purchase Agreements (BPAs). VA saved some $85 million from these contracts and BPAs in 2001 while DoD saved over $100 million in the same year for all national contracts. To date, VA and DoD have identified 50 drugs that may have joint contracting possibilities in 2002.

This initiative, coupled with joint ventures and sharing agreements, would enhance coordinated purchases of expensive equipment and help reduce incidents of excess regional purchases. The American Legion would like to see an emphasis on more sharing opportunities considered with pharmaceuticals and medical/surgical supplies.

VHA's reputation in medial and prosthetics research is stellar. VHA is also recognized as the largest trainer of health care professionals. This creates a logical opportunity for closer cooperation and coordination between VA and DoD to result in a win-win scenario. Through its affiliation with medical schools and academic medical centers, as well as other research institutions, VHA continues as a major national research asset. VHA conducts basic clinical, epidemiological and behavioral studies across the entire spectrum of scientific disciplines. In recent studies, VHA's patient safety procedures have received national recognition for

excellence. In terms of nuclear, chemical, and biological warfare, MHS remains the nations' leading expert in casualty care. Both systems would benefit from shared expertise and best practices in these and other areas.

The events of September 11, 2001 emphasize the national need for improved emergency preparedness for combat and civilian casualties. A major VHA mission is to serve as a contingency back-up for DoD medical services and support the National Disaster Medical System. Clearly, close cooperation between VHA and DoD on a daily basis greatly enhances the knowledge of and confidence in the capabilities of each Department.

Near-term Goals

- Coordinated purchasing -- A renewed focus on joint efforts between the two agencies to share services and purchases of medical/surgical and pharmaceutical supplies.

- Enhanced sharing agreements -- The American Legion would like to see maximum utilization of sharing agreements between all regional VA, DoD and TRICARE health care providers.

- Implemented Medicare subvention -- The American Legion cannot over emphasize the importance of the approval of Medicare subvention for all enrolled Priority Group 7 Medicare-eligible veterans and TRICARE for Life veterans being treated for nonservice-connected conditions. This first step is essential in the process of improving health care delivery for this nation's veterans. The American Legion continues to advocate for the approval of Medicare subvention for VHA.

- Enhanced Joint Graduate Medical Education – The American Legion recommends the expansion of joint medical education and training, as well as joint research and development opportunities would greatly enhance the services of both agencies.

Mid-term Goals

- Improved billing and collection -- The American Legion recommends either providing enhanced information technology and training to improve VA's billing and collection capabilities or purchasing this service from the private sector.

- Shared patient medical records -- The use of technology, such as bridging, would help alleviate current problems of sharing vital information between agencies.

Long-term Goals

- Contracted TRICARE Services -- The American Legion strongly recommends that Congress allow VA to become a primary contractor for DoD health care system. Legislation would be required that would allow VA to act as a primary contractor and be able to compete with the private sector for these contracts. Instead of VA being the subcontractor, it would become the contractor using VHA medical facilities to provide care

to TRICARE beneficiaries. This level of cooperation would go a long way in reducing costs for all three Federal agencies DoD, VA and the Centers and would provide consistent, coordinated quality health care for the entire patient population. The American Legion believes this would be the ultimate joint venture that would better coordinate the delivery of quality health care among the Federal agencies without obfuscating their unique missions.

Summary

As a grateful nation, it is a civic responsibility to find the most efficient way to deliver quality and timely health care to this very unique population. The American Legion believes allowing Medicare subvention in VA would eliminate some existing barriers and enable VA and DoD to work closer together in the treatment of TRICARE beneficiaries for nonservice-connected conditions. The American Legion strongly recommends seeking additional joint ventures opportunities between VA, DoD and TRICARE. The American Legion believes joint ventures offer many more opportunities for cost savings through purchasing of pharmaceuticals and medical/surgical supplies and contracting of services. Advances in information technology should be explored to remove current technology barriers that seem to exist with the exchange of critical information between these health care providers. Finally, best practices of those that have been successful absolutely need to be shared and implemented.

The American Legion believes the success or failure in greater VA and DoD sharing rests in the leadership. As wartime veterans, time and time again we witnessed victory snatched from the jaws of defeat because resourceful and determined leaders found solutions to reach their objectives. Each soldier, sailor, airman, and Marine can cite an impossible task that was accomplished because the *Old Man* gave the order to get it done. Effective leadership seeks results not excuses. The objective must be ***tell me how to achieve this goal*** rather than ***tell me why it can't work***. The American Legion recommends constructive planning in lieu of bureaucratic obstruction be applied in developing joint ventures, resource sharing agreements, and other areas of cooperation.