HEARING ON VETERANS' HEALTH RESOURCES

Thursday, March 7, 2002

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON MILITARY PERSONNEL, COMMITTEE ON ARMED SERVICES,
SUBCOMMITTEE ON HEALTH, COMMITTEE ON VETERANS' AFFAIRS,

Washington, D.C.The subcommittees met, pursuant to call, at 11:00 a.m., in Room 2118, Rayburn House Office Building, Hon. John McHugh [chairman of the Military Personnel subcommittee] presiding.

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

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

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

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

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

Why do they find themselves with sharing initiatives whose value constitutes, in relative terms, a very small, even some would say, minuscule amount compared to the $35 billion in annual combined health care budget of both departments?

Why do they find themselves with DOD and VA health care delivery, workload, beneficiary information, management, cost ac-

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counting and financial information systems that remain, to a very large extent, incompatible and unable to communicate, despite numerous studies over the years pointing out these inadequacies?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

We have changed in the VA system the delivery of health care and have, in addition to trying to strengthen our hospitals across the country, have moved in a way that creates community out-patient clinics in many locations. And I would like to know from our witnesses the effect of providing services in nearly 800 CBOCs across the country, how this will result in the cooperation that can occur between the VA and the DOD. But with all this new demand, is there room within the system for additional sharing?

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

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

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

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

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

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

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

Mr. SNYDER. Thank you, Mr. Chairman. I have nothing to add to either your message or eloquence nor of Chairman Moran's. Just one procedural note: When we had our hearing June 21 of last year, I had submitted some questions for the record to Dr. Garthwaite, and we received those answers I think three days ago. That does not seem to me to be a timely response, and while we have—maybe there is some explanation for it, but I just—Mr. McHugh's letter to me is dated March 5.

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

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

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

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

Mr. MCHUGH. Thank the gentleman. Thank him as well for his long hard work on this issue.

We now recognize the first panel, a man of such stature he is his own panel.

[Laughter.]

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

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

STATEMENT OF HON. CHRISTOPHER H. SMITH, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

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

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

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

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

tive ways to make it possible for our veterans and our men and women in uniform to get the best possible health care.

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

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

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

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

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

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

For example, at the San Diego VA Medical Center, the fiscal year 2001 budget is $202 million, and at the Balboa Naval Medical Center, the fiscal year budget is $338 million. Although these facilities are only a few miles apart, no clinical sharing occurs between the two. Does anyone doubt that money could be saved by reducing duplication of services, and realizing the synergies of where there can be a sharing of just doing it?

For too many neighboring VA and DOD facilities, separate management and operations are the only way they conceive of doing business—that is the way we always did it, let's just keep doing it that way—even when another federal medical facility, also supported by public dollars, is just a mile or two or a stone's throw

away. I am convinced that this separateness is the result, at least in part, of deeply ingrained habits, entrenched organizational cultures and long-standing turf battles.

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

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

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

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

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

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

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

In addition, the demonstration projects would provide the enhancement of graduate medical educational programs at the five sites. This will create a great opportunity for health care profession students by giving them a combined exposure that has not been

available to them before. It would also bring better awareness and understanding of differences in the two beneficiary populations for new and experienced health care professionals alike. We believe this is a good framework for moving this process along.

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

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

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

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

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

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

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

[The statement of Mr. Smith follows:]

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

I want to give you a chance to—first of all, let me preface and say that we have had a lot of opportunity to look at your bill. There is a lot in it that, at least to me personally, makes sense. As happens in any piece of legislation, you try to talk to folks who have either an administrative interest or an interest, in this case, with respect to patients and those who would utilize the facilities.

And one of the things we heard from some of the outside groups is that they felt your bill took an integration approach. We get hung up on semantics far too often, and what they supported was

rather a sharing. I think the concern is probably predicated upon the largely different beneficiary populations and the specific needs, and they were worried that a true integration might diminish, erode the quality of care to some of those specific needs.

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

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

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

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

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

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

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

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

And the idea of the seamless transition, which has been highlighted in previous reports to Congress, including the report chaired by now Secretary Principi, talked about that seamless transition. Why is it that we do not have the data on certain medical personnel records because the interface has not occurred and the pass-off of the baton is not so easily made from DOD to the VA. It would be nice if we had from sign-up to VA perhaps a provision of care that we know who this patient is.

So I see nothing but positives coming out of it if it is done smartly. And I would hope, given all the eyes and ears that are looking

at it and the distinguished people that will be testifying after me, once the political decision has been made to do it and that the roadblocks are not done at some mid-level to say it cannot be done, it can be done, and it should be done, and that does not mean five years from now we will realize savings that get plowed right back into both systems.

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

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

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

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

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

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

Mr. MCHUGH. I thank the gentleman.

Yield to Chairman Moran.

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

[Laughter.]

Mr. MCHUGH. Thank you.

Mr. Snyder.

Mr. SNYDER. Thank you, Mr. Chairman.

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

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

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

Mr. MCHUGH. Thank the gentleman.

Mr. Evans. No questions.

Mr. Ryan? My goodness, we are doing well.

Mr. Rodriguez?

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

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

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

And, unfortunately, I came up at a time when I was just getting ready to leave to my next meeting, but I will be looking at your legislation. Because I do feel that there are some areas where we can coordinate. I know that in some areas they are not getting third party reimbursements the way they should, both in the Department of Defense and I have looked at some language there in the past, but we need to see how we might be able to improve on that, especially with the light of TRICARE, how the services can

be provided both for the veteran at the DOD and for the retiree at the VA and how that might come about in a more smoother.

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

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

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

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

Mr. MCHUGH. Ms. Davis?

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

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

Mr. SMITH. Thanks, Ms. Davis.

Mr. MCHUGH. Mr. Wilson?

Mr. Boozman.

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

Mr. MCHUGH. Mr. Miller?

Mr. MILLER. I want to thank Chairman McHugh and Moran for holding this hearing and certainly enjoyed hearing your comments, Mr. Chairman. And I just want to make quick statement. I am pleased to serve on both subcommittees, Health and Benefit. And my district in northwest Florida is the largest index service net-

work in the Veterans' Health Administration. It is home to over 110,000 veterans who are primarily served by two outpatient clinics.

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

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

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

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

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

[Laughter.]

Other than that I have no excuse, and I apologize to the gentleman.

Mr. Miller.

Mr. Simmons?

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

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

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

And if you look at what our men and women are doing in Afghanistan and elsewhere around the world today, we have integrated the Reserves with the active component, and that has in-

creased the capabilities of our fighting forces dramatically, and I think it is a plus, and it is a positive.

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

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

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

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

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

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

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

As I indicated earlier, last year when we got the budget submission from the administration, they actually had to do, in this year's, an updated estimate for the year 2002, because it had climbed so precipitously. As a matter of fact, the number year over year, as I said at the outset, is about 775,000 more unique patients. And when you factor that out into number of patient calls at the outpatient clinics and the other care facilities, it becomes very, very significant in terms of patient load and cost.

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

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

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

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

Mr. SIMMONS. Thank you, Mr. Chairman.

Mr. SMITH. Thank you.

Mr. MCHUGH. Thank you.

Mr. Schrock?

Mr. SCHROCK. Thank you, Mr. Chairman.

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

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

We have a VA hospital in Hampton, which is north of the tunnel from where I live in Virginia Beach, in the Norfolk area, and I

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

Mr. SMITH. Thank you.

Mr. MCHUGH. Mr. Stearns?

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

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

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

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

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

Mr. SMITH. Only to say thank you, but frankly it is a team effort, and Mr. McHugh, Mr. Moran has been walking point on the Health Committee, as you did before as chairman of the Health Committee for VA. Matter of fact, you are the prime sponsor of the Millennium Health Care Act, what continues to be largely unfulfilled, even though the word of the bill said, ″shall,″ not ″may,″ and that has to do with resources. And if we free up resources, there could be more long-term care beds made available to follow the letter and the spirit of your legislation. And Mr. Moran has been very

proactive as chairman of our committee, and I deeply appreciate his leadership.

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

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

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

And we would start with Mr. Taylor.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Thank both of the chairmen.

Mr. MCHUGH. Thank the gentleman.

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

Mr. ORTIZ. Thank you so much for having this hearing.

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

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

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

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

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

We talk about retention problems, my friends. How are we going to be able to retain when we do not give them what we offered

them in the beginning. And I thank you, Mr. Chairman, both of you, for giving me this opportunity to be here with you today.

Mr. MCHUGH. I thank the gentleman and for his efforts and his deep concern.

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

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

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

[Laughter.]

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

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

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

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

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

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

I am pleased to be here today to discuss coordination of health care resources between my Department of VA and the Department of Defense. Administration has identified enhanced collaboration between the two departments, and their health care system is one of its top priorities. It is mentioned in the president's management

agenda as a priority item, one of 14 items so designated in that agenda, and it is a matter of quite serious concern and focus between our two departments.

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

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

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

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

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

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

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

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

We have some very tough obstacles with regard to sharing in TRICARE. And there are limits to sharing due to different structures, different purposes, authorities and missions between the two departments. This is also a new team that you have before you to meet this challenge, but newness certainly is no excuse. The opportunity is clear, the rationale for extensive sharing between VA and DOD is compelling. We have ample authority the Congress has given us. We have made some track record of success, but it is not enough. We are determined to deliver much more.

Thank you, and I would be happy to answer any questions from members.

[The statement of Mr. Mackay follows:]

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

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

STATEMENT OF DAVID CHU

Mr. CHU. Very good, sir. And I will be brief in those circumstances.

Thank you, Mr. Chairman. It is a great privilege to be here and discuss with the committee our vision for how we improve the partnership between the Department of Defense and the Veterans' Administration in the delivery of health care. We put enormous value on that existing relationship. It is our hope that this becomes more than sharing over time and becomes indeed a proactive partnership, a strategic partnership between the two departments.

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

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

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

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

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

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

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

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

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

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

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

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

[The statement of Mr. Chu follows:]

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Mr. MCHUGH. Thank you very much, Mr. Secretary.

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

[Recess.]

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

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

STATEMENT OF NANCY DORN

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

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

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

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

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

I would just mention a couple of areas and then stop so we will have some time for questions. Two overarching areas of coordination that we are very interested are information technology and facility sharing. These are key issues from the Office of Management

and Budget's perspective. Sharing information technology can make a world of difference—speeding up service, ensuring safer health care and informing veterans of earned entitlement. In addition, it can transport information from one department to another, continually providing fuel for innovation and improvement of service.

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

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

Active duty personnel, dependents and veterans all benefit by DOD and VA sharing facilities when appropriate. The two departments share less than 10 facilities today, but we look forward to making some improvements on that in the very near future. In many communities, DOD and VA hospitals are close together, as Chairman Smith noted. In many areas, we think we can achieve great advancements in delivery of services if we can get a coordinated, consolidated effort.

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

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

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

In closing, I hope that we can emphasize how important the DOD and VA coordination is to the president and some of the specific areas that the administration is pursuing to ensure top quality services to military members and their families and veterans. We still have a lot of work to be done, as only about $100 million, less than a quarter of 1 percent, of a $40 billion budget of VA passes from one department to another.

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

[The statement of Ms. Dorn follows:]

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Mr. MORAN. Thank you so much for the OMB perspective.

Dr. Wilensky, welcome and look forward to your testimony.

STATEMENT OF GAIL WILENSKY

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

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

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

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

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

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

We have had to recognize the fact that these two departments treat different populations. They have different missions, they clearly have different cultures and traditions, and all of those impact the ability to have sharing occur. We are also reviewing the many recommendations that people have made in the past. As has

been pointed out to us, and as all of you are aware, there have been several commissions preceding us. We want to understand which of the recommendations were implemented, and if they have not been implemented, what was the impediment toward their implementation?

We have staffed these work groups with some consultants who are not only subject matter consultants but who come out of the VA and DOD. We thought it was very important that we have people on board who understand those cultures. We have also, with only a little prodding, been able to have some excellent detailees from both the VA and the DOD assigned to the task force, and they, with subject matter expertise, along with a small, more permanent staff, formed the basis of the people who are doing the staff work for the task force.

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

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

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

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

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

[The statement of Ms. Wilensky follows:]
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Mr. MORAN. Doctor, thank you very much.

Let me begin with just a couple questions for you, Dr. Wilensky. What point in time do we have a recommendation?

Ms. WILENSKY. Our plan is in July we will have our interim report. It is our expectation there will be some broad level recommendations, more of the 10,000-to 30,000-foot level recommendations across the area, a vision chapter that describes where we see this system going, and in some areas, some specific recommendations, probably pharmaceutical facilities, those areas that are easier to get our arms around.

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

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

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

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

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

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

Ms. WILENSKY. There are clearly barriers.

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

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

the military facility—this is where they have been receiving care—and some reluctance to change those identifications.

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

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

Mr. MORAN. Doctor, thank you.

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

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

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

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

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

Dr. Snyder.

Mr. SNYDER. Thank you, Mr. Chairman.

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

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

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

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

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

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

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

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

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

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

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

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

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

Ms. WILENSKY. Let me give you some immediate reactions. One is a constant monitoring. There is nothing like having high-level re-

porting back to the Congress what has and has not been done to force attention to the issue. So I would encourage you to consider this in a serious oversight way.

I am impressed with the discussions that I have had with Dr. Chu and Dr. MacKay and Secretary Principi also, that they regard this seriously, that they would like this to happen and are frustrated that there has been so little progress. I am impressed that both these gentlemen are involved in resurrecting the council that had not been active to try to work out sharing. So it is my impression that they are looking to find ways to have this happen.

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

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

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

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

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

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

Ms. WILENSKY. I would be glad to.

Mr. SNYDER. Thank you, Dr. Wilensky.

Thank you, Mr. Chairman.

Mr. MORAN. Mr. Wilson.

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

And I want to give a report to Dr. MacKay that I had a district meeting three weeks ago, and it was at the Dorn VA Hospital. And I was very impressed that it was widely advertised that we would have this meeting on veterans' issues. And it amazed me that people came and actually had—instead of horror stories, people came

and were asking questions. But in the process of asking question, indicating the quality of care that they received, that they felt like it was first class. So I just want to thank all of you and the entire panel for being here today.

Thank you, Mr. Chairman.

Mr. MORAN. Mr. Ortiz.

Mr. ORTIZ. Thank you, Mr. Chairman. I also would like to thank the panel for being with us today. I just have maybe a couple of questions that are not really parochial questions. Because all we have to do is look at the redistricting and some of the states that loses members and some of the states that gain. It just so happens that we have a big population of elderly veterans who are now moving south because of the weather conditions.

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

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

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

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

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

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

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

to match growths in veteran population, growth in demand for services with our infrastructure.

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

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

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

Mr. Chairman, thank you for your time.

Mr. MORAN. Thank you, Mr. Ortiz.

Mr. Kirk?

Mr. KIRK. Thank you and thank you for the courtesy since I have deserted this subcommittee to still be here. And I thank you. I also want to thank Dr. MacKay for coming, and it is great that you have given up your F-14 to help lead the VA.

And Dr. Chu, we were very glad to have you at Great Lakes to see what is happening there.

And, Nancy, for many, many years, and congratulations on your new position.

And, Dr. Wilensky, probably no one knows about paying for health care better than you do.

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

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

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

We have a working group that has been charged with gathering the facts and figures that are necessary to make a good business decision here. It has to come back to us in the late spring time

frame. And so I am very hopeful that shortly thereafter we can evaluate the options and decide on a course of action.

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

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

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

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

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

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

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

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

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

I am delighted that some of our TRICARE contractors take a similar view and are aggressively trying to promote the use of VA facilities as part of their networks. And I think all these are ingredients in a long-term better solution, both for those for whom we owe the care as well as for the taxpayer.

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

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

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

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

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

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

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

Mr. KIRK. Great. Thank you.

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

We would welcome our third panel to the table. Robert Washington is the director of Membership Services for the Fleet Reserve Association and the co-chair of the Military Coalition for Health Care Committee; Deirdre Parke Holleman is the co-chair of the Health Care Committee of the National Military Veterans' Allliance; Steve Robertson, the director of Legislative Affairs for the American Legion; Harley Thomas, health policy analyst for Paralyzed Veterans of America; Joy Ilem, assistant national legislative director for Disabled American Veterans; and Dennis Cullinan, director of Legislative Services for the Veterans of Foreign Wars of the United States. We welcome you all to this joint meeting of our subcommittees.

Mr. Washington?

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

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

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

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

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

The coalition strongly recommends development and deployment of a common DOD-VA medical record as quickly as possible, along with the capability to exchange data seamlessly between the two systems using appropriate privacy protections. The coalition recommends a review of the pharmaceutical practices of both depart-

ments and mail order pharmacies and urges improved cooperation between the two agencies in this area.

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

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

Long-term opportunities, the coalition strongly recommends upholding the principle that military retired veterans have earned and deserve access to both VA and VA CARES system, and they must not be forced to forego either benefit. Budget-driven proposals should be resolved by the DOD and VA and not placed on the backs of those who have earned those benefit through service to their country.

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

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

[The statement of Mr. Washington follows:]

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

Mrs. Holleman?

STATEMENT OF DEIDRE HOLLEMAN

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

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

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

that DOD and VA follow Medicare's claim forms, language and definitions.

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

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

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

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

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

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

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

[The statement of Ms. Holleman follows:]

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Mr. MORAN. Thank you very much.

Mr. Robertson?

STATEMENT OF STEVE ROBERTSON

Mr. ROBERTSON. Thank you, Mr. Chairman. The American Legion appreciates the opportunity to be here, but in the same token, we are very disappointed that we are here. The fact that the military and DOD and VA has had this opportunity for a couple of decades now, we are disappointed that we are having to come here

and address this issue, especially as veterans who are taught from the very beginning of basic training how important teamwork is.

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

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

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

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

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

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

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

[The statement of Mr. Robertson follows:]

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Mr. MORAN. Thank you very much.

Ms. Ilem?

STATEMENT OF JOY ILEM

Ms. ILEM. Thank you, Mr. Chairman. On behalf of the more than 1 million members of Disabled American Veterans and its auxiliary, I am pleased to express our views on health care sharing by the Department of Defense and Department of Veterans Affairs.

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

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

We are concerned about legislative proposals in Congress that would contract our veterans health care to private sector or create some sort of a hybrid VA-DOD health care system. DAV is concerned that these initiatives are primarily cost reduction efforts with potentially negative effects on services for both VA and DOD beneficiary populations.

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

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

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

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

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

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

[The statement of Ms. Ilem follows:]

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Mr. MORAN. Thank you. Mr Cullinan?

STATEMENT OF DENNIS CULLINAN

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

Before we address the opportunities for sharing between DOD and VA, we too believe that it is important to emphasize that they are two separate and distinct entities with different missions: One, to fight and win the nation's wars, and the other to care for those who bear the scars from those wars. While we strongly support and encourage their working together to best provide health care to their patient population, they and their missions must remain separate and distinct.

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

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

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

beneficial agreements should be met with swift departmental and congressional action.

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

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

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

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

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

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

[The statement of Mr. Cullinan follows:]

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Mr. MORAN. Thank you for your statement.

Mr. Thomas?

STATEMENT OF HARLEY THOMAS

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

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

As Chairman Smith pointed out earlier today, the VA suffers from chronic underfunding. This year alone, the president's budget proposal, as Chairman Smith stated, is approximately $3 billion short. This has been this way for several years. In the first session of this 107th Congress, there were many new initiatives passed and became law for veterans. However, the appropriators have not

seen fit to allocate any funds to support those initiatives. The Veterans Millennium bill that was passed in 1999, the long-term terror aspects of that bill has not been fully implemented. And why? Because there is no money in the VA system to do that.

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

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

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

VA typically treats a population of older Americans, chronically ill and disabled veterans. As the nation's leader in such specialized services as blind rehabilitation, spinal cord injury, and mental health, the VA provides the full continuum of health care services to veterans, including nursing homes and assisted living in long-term care facilities, to adult daycare and geriatric services.

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

Typically DOD medical facilities treat younger and much healthier patients.

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

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

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

gained by forcing patients of one system to use the facilities of the other.

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

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

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

Thank you, and I will be happy to answer any questions.

[The statement of Mr. Thomas follows:]

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Mr. MORAN. Mr. Thomas, thank you.

Dr. Snyder?

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

I thought, Mr. Washington, you captured the standard well, that whatever we do it needs to result in the same level of services, hopefully with some cost savings or efficiency or maybe not any savings but a greater level of services for whoever we are serving. I think that is the standard that everyone wants.

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

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

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

Just the last thing I would say, I think your role is a very important one here as far as being part of this monitoring of the systems. I thought some of the specific suggestions you made, but just in the course of your discussions with the administration, it reminds me

a little bit of when people come to me about issues and how to impact an issue.

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

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

Thank you, Mr. Chairman.

Mr. MORAN. Thank you, Mr. Snyder.

Mr. Wilson?

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

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

Mr. MORAN. Mr. Washington and Mr. Thomas, it seems to me that your testimony in particular points out cost savings that can occur in procurement issues, pharmacy, but a real reluctance to share the responsibility for the providing of direct health care services to veterans and members of our military. Is that an accurate brief summary of your thoughts?

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

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

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

I would be glad to have any response from any of the members of our panel.

Mr. Cullinan?

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

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

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

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

The things that seem so obvious are not being done. And I mean this is where leadership comes in. And I firmly believe, and the American Legion firmly believes, that it starts with the top and goes down. If it is not a command concern or command interest, if it is not being driven from the top and people being held accountable for not doing it, we will continue to maintain status quo.

Mr. MORAN. Mr. Thomas?

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

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

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

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

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

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

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

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

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

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

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

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

And, as I said in my opening remarks, I think that circumstances we face today in the war on terrorism is a great opportunity for us

on the VA Committee who look after veterans after they return from service and those who are on the DOD, on the Armed Services Committee, carrying about those who serve currently, that they are very much blended. And the consequences of failing to take actions during service have tremendous consequences upon return of those men and women home.

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

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