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Report to Congressional Requesters

May 2000

VA AND DEFENSE HEALTH CARE

Evolving Health Care Systems Require Rethinking of Resource Sharing Strategies

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Abbreviations

AFB	Air Force Base
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
DOD	Department of Defense
MEPS	military entrance processing station
MMSO	military medical support office
MTF	military treatment facility
VA	Department of Veterans Affairs
VAMC	VA medical centers
VISN	Veterans Integrated Service Network

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Health, Education, and
Human Services Division

B-282020

May 17, 2000

The Honorable Clifford Stearns
Chairman, Subcommittee on Health
Committee on Veterans Affairs
House of Representatives

The Honorable Terry Everett
Chairman, Subcommittee on Oversight and Investigations
Committee on Veterans Affairs
House of Representatives

The Honorable Christopher Shays
Chairman, Subcommittee on National Security,
Veterans Affairs and International Relations
Committee on Government Reform
House of Representatives

The Department of Veterans Affairs (VA) and the Department of Defense (DOD) provide health care services to more than 12 million beneficiaries. VA and DOD operate a total of more than 700 medical facilities at a combined cost of about $34 billion annually. To promote more cost-effective use of these resources and more efficient delivery of care, we recommended in 1978 legislation that would encourage the sharing of federal health care resources between VA and DOD.[1] In May 1982, the Congress enacted the VA and DOD Health Resources Sharing and Emergency Operations Act (Sharing Act).[2] Since then, we have identified

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

[2]P.L. 97-174, 96 Stat. 70.

several eligibility and reimbursement policies that have limited sharing between VA and DOD[3]; legislation has been enacted to remove these obstacles.[4]

To learn more about the status of sharing, you asked us to (1) describe the benefits gained from sharing, (2) determine the extent to which VA and DOD are sharing health care resources, and (3) identify any barriers and challenges VA and DOD face in their efforts to share health resources. In addition, you asked us to identify opportunities for improving VA and DOD's annual reporting to the Congress on their sharing activities.

For this review, we spoke with VA and DOD headquarters officials and obtained information through a mail survey sent to over 400 VA medical facilities and DOD units participating in local sharing agreements. We conducted site visits at four VA and three DOD medical facilities participating in local sharing agreements in Florida, Illinois, and Virginia. In addition, we visited two sites, New Mexico and Nevada, that have initiated joint venture agreements to provide integrated VA and DOD services in a single facility. We also visited the joint venture site in Florida, where VA and DOD share space in a new jointly constructed facility, and conducted telephone interviews with officials at the other sites where VA and DOD share space: Alaska, California, Hawaii, Oklahoma, and Texas. We also analyzed information in the VA/DOD Federal Health Care Resources Sharing Database, which is solely maintained by VA and used to develop the agencies' joint annual reports to the Congress, and held discussions with DOD's managed care contractors to obtain their views on the resource sharing program. (For details on our methodology, see app. I.) We conducted our work between January 1999 and April 2000 in accordance with generally accepted government auditing standards.

Results in Brief

Over the last 20 years, VA and DOD have pursued opportunities to share health care resources through local agreements, joint ventures, national sharing initiatives, and other collaborative efforts. As both providers and

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

[4]The National Defense Authorization Act of 1990 and 1991 authorized the use of Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) funds to pay VA for services rendered to CHAMPUS beneficiaries.

receivers of services, local VA and DOD officials identified a number of benefits—qualitative and quantitative—resulting from the sharing program. As a provider of services, VA most frequently cited increased revenue as a benefit and DOD most often cited the opportunity to enhance staff proficiency. VA and DOD providers also cited fuller utilization of staff and equipment as benefits. As a receiver of services, VA cited improved beneficiary access and DOD cited reduced cost of services as benefits. In addition, some cost savings were measured. For example, some facilities compared the costs associated with sharing and the costs of purchasing services from private providers. Some cost savings were measured by determining the costs avoided.

Through our survey and fieldwork, we found that while a majority of the local and joint venture sharing agreements were active, activity was concentrated. For fiscal year 1998, sharing activity occurred under 412, or about three-quarters, of the existing local sharing agreements. Direct medical care accounted for about two-thirds of services exchanged; the remaining one-third included ancillary services, such as laboratory testing, and support services, such as laundry. However, most of this activity occurred under a few agreements and at a few facilities, usually in locations where multiple DOD facilities were near VA hospitals or where DOD facilities provided specialized services. Overall, 75 percent of direct medical care episodes occurred under just 12 agreements for inpatient care, 19 agreements for outpatient care, and 12 agreements for ancillary care. Reimbursements for care provided under sharing agreements—another indicator of activity—were similarly concentrated. In fiscal year 1998, three-quarters of the $29 million in reimbursements for provided care was collected by only 26 of the 145 facilities participating in active agreements. At the joint venture sites, where another $21 million in services was exchanged, we found activity was concentrated at the two locations where VA and DOD integrated many hospital services and administrative processes. Specifically, almost 300,000 episodes of care were provided, and $3.2 million in cost avoidance was measured at these two locations. Participation by local facilities in 10 nationwide sharing efforts or other collaborative efforts outside the Sharing Act was minimal.

VA and DOD officials reported a number of barriers that could jeopardize current and future sharing agreements. Among the barriers identified most often by both VA and DOD, two are long-standing barriers that we have previously reported on: inconsistent reimbursement and budgeting policies and burdensome agreement approval processes. The lack of flexibility to negotiate rates that are mutually beneficial has discouraged sharing and

impeded collaboration. A more recent barrier—one that has major implications for the nature and future of sharing—centers on DOD policies and guidance in implementing its managed care program. Specifically, a DOD legal opinion and subsequent policy in effect prohibits military treatment facilities (MTF) from using existing sharing agreements with VA for direct medical care—which constitute the majority of the sharing agreements. Consequently, DOD's contracts with private health care companies may supersede the sharing of direct medical care between VA and DOD facilities. While the policy supports VA facilities' participation in the contractors' health care networks, the military Surgeons General and local VA and DOD officials told us that the policy is causing confusion over what services can be shared. In light of this policy and other recent changes in VA's and DOD's health care systems, we are recommending that DOD reevaluate its position regarding sharing and, together with VA, determine what actions are needed to ensure the most cost-effective use of federal health care resources.

Despite the benefits and activity reported to us through our survey and fieldwork, the lack of comparable historical information precluded an assessment of the sharing program's actual progress. Although VA and DOD's joint database shows substantial growth in the number of local sharing agreements, it does not show the volume of activity—the actual number of services provided and the compensation for each of these services—under these agreements, nor does it capture activity under the joint venture agreements and the 10 national initiatives. Collaborative efforts occurring outside the act—another important indicator of sharing—are also not systematically recorded. In addition, data in VA and DOD's joint database are of questionable accuracy. For example, we found discrepancies between the number of agreements reported in the database and the number actually in effect. Without a baseline of activity or complete and accurate data, we could not analyze trends in the level of sharing activity over the years. To better enable VA and DOD to monitor sharing activity and measure the program's progress, we are recommending that VA and DOD broaden the scope of the information captured in their joint database and improve the quality of the information.

Background

VA operates one of the world's largest health care systems, spending about $18 billion a year to provide care to approximately 4.1 million veterans who receive health care through 181 VA medical centers and 272 outpatient clinics nationwide. DOD spends about $16 billion on health care for over

5 million beneficiaries, including active duty personnel, military retirees, and dependents. Most DOD health care is provided at the more than 500 Army, Navy, and Air Force military hospitals and clinics worldwide.

To encourage the sharing of federal health care resources between VA and DOD, the Sharing Act authorizes VA medical centers (VAMC) and DOD's MTFs to become partners and enter into sharing agreements to buy, sell, and barter medical and support services. The law states that the head of each medical facility of either agency can enter into agreements; local officials propose the agreements, and VA and DOD headquarters officials review the proposals for final approval. Agreements can be valid for up to 5 years.

VA and DOD sharing activities fall into four categories:

- *Local sharing agreements* allow VAMCs and MTFs to exchange health and support services to maximize their resources. Under a local sharing agreement, partners can be a provider of services, a receiver of services, or both. Health services shared under these agreements include inpatient and outpatient care; ancillary services, such as diagnostic and therapeutic radiology; dental care; and specialty care services, such as services for the treatment of spinal cord injury. Shared support services include administration and management, research, education and training, patient transportation, and laundry.
- *Joint venture sharing agreements*, as distinguished from local sharing agreements, aim to avoid costs by pooling resources to build new facilities or to capitalize on existing facilities. There are three types of joint ventures: (1) VA and DOD services integrated in a single facility, (2) VA sharing DOD facility space, and (3) the construction of a separate VA facility adjacent to an existing DOD facility on DOD property. Joint ventures require more cooperation and flexibility than local agreements do because two separate health care systems must develop multiple sharing agreements that allow them to operate as one system. VA and DOD partners must work together to draft these agreements and establish operational procedures for the joint facility, such as joint medical reviews and patient recordkeeping.
- *National sharing initiatives* are being developed by the VA/DOD Executive Council, a management-level group created under the Sharing Act and revitalized in February 1998 as part of the Vice President's Reinventing Government initiative. The council's goal is to identify and implement interagency initiatives that are national in scope—such as the joint disability discharge initiative, which eliminated the duplicative

physical examinations that military personnel were required to undergo to be discharged and receive VA disability benefits. The council consists of each department's chief health officers and key deputies, and the Surgeon General from each military branch. The council generally meets monthly.[5]

- *Other collaborative efforts* not specifically covered under the Sharing Act are also being explored by local VA and DOD facilities. For example, in 1998, VA and DOD collaborated on the joint purchasing of pharmaceuticals, laboratory services, medical supplies and equipment, and other support services.

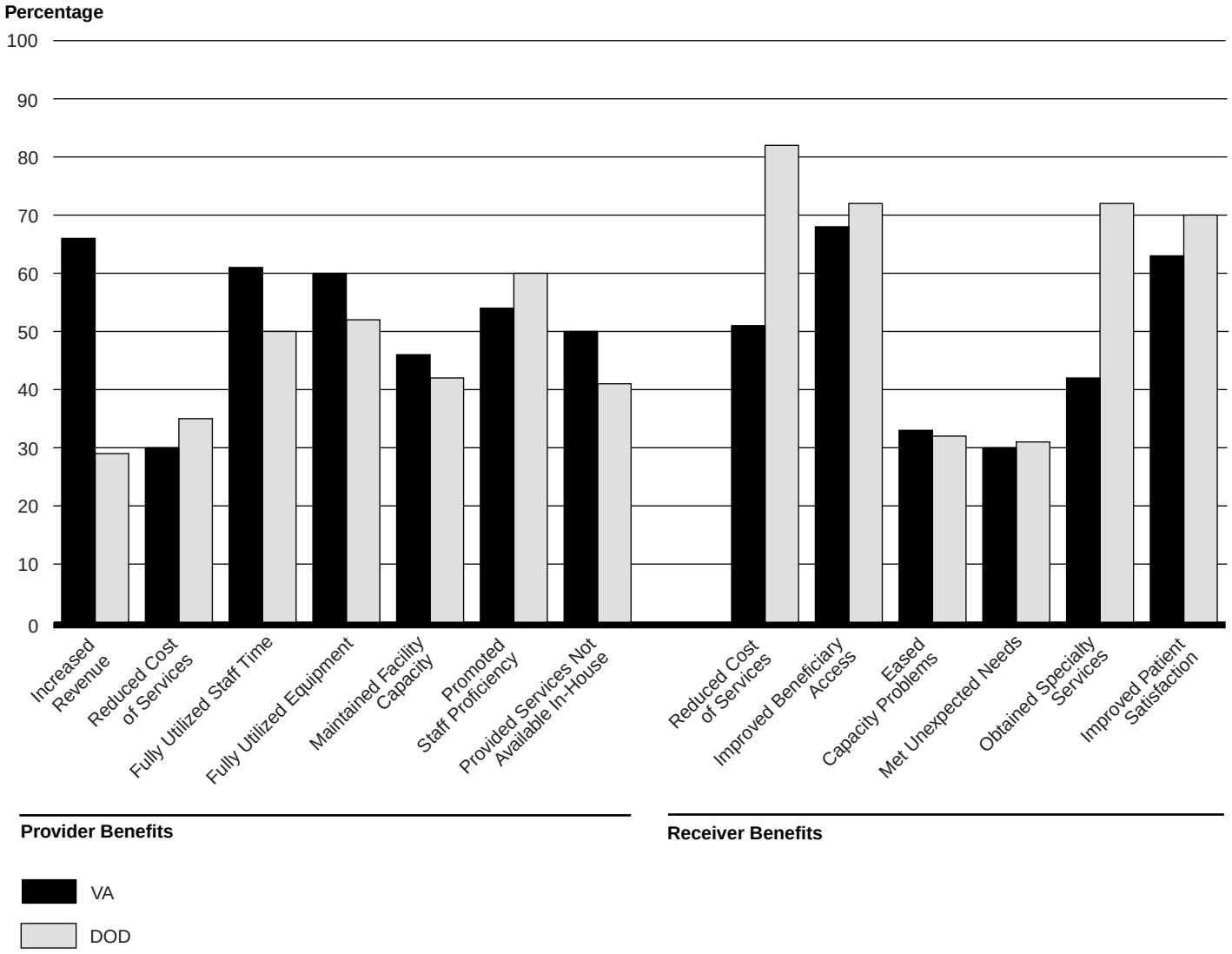
As required by the Sharing Act, VA and DOD report annually to the Congress on the status of VA/DOD sharing.

Local VA and DOD Partners Cite Numerous Benefits to Sharing

Over the years, VA and DOD have identified numerous benefits associated with sharing health resources, including significant improvements in resource and facility utilization at the local level. VA and DOD partners responding to our survey attributed a number of specific benefits to their local sharing agreements. (See fig. 1.) As providers, VA survey respondents most frequently cited as benefits increased revenue and fuller utilization of staff and equipment; DOD respondents cited increased medical staff proficiency through, for example, broadening the range of populations that physicians treat, such as older patients and patients with more severe or multiple conditions. As receivers, about 70 percent of both VA and DOD respondents cited reduced cost of services and improved beneficiary access and patient satisfaction as benefits to sharing.

[5]The council is responsible for preparing five reports on VA/DOD Sharing, as required by the Secretaries of VA and DOD to meet a congressional mandate. One report has been issued; four are pending.

Figure 1: Types of Benefits Reported by VA and DOD Survey Respondents



Source: GAO survey, 1999.

Most Sharing Activity Concentrated Under a Small Percentage of Agreements and Facilities

To measure the activity that occurred under sharing agreements in fiscal year 1998 and establish a baseline for measuring future growth, we surveyed VA and DOD sharing partners on the health and support services they provided under sharing agreements and the type of compensation—measured by reimbursements and barter arrangements—made to the facility providing the service. We found that under three-quarters of the agreements, services were provided, compensation was made, or both. Most services provided were for direct medical care. However, activity was concentrated under a small percentage of agreements and facilities, usually in locations where multiple DOD facilities were near VA hospitals or where DOD facilities provided specialized services. Activity under the joint ventures, while generally robust, was similarly concentrated at the two sites where the local partners have integrated many hospital services and administrative processes. These two joint ventures reported over 300,000 episodes of care and $3.2 million in actual cost savings to the government, compared with the remaining four joint ventures that were operational as of 1998, which reported a total of about 60,000 episodes of care and about $21.5 million in reimbursements.

Local participation in the 10 national sharing initiatives, even those that have been fully developed, has been minimal. Some local VA and DOD sharing partners also reported sharing arrangements not covered by the Sharing Act, such as using joint purchasing agreements to augment the individual buying power of VA and DOD. However, the data for these arrangements have not been systematically collected and consequently, the benefits are not readily quantifiable.

About Three-Quarters of Agreements Were Active, With Direct Medical Care Accounting for Most Services Provided

In fiscal year 1998, 72 percent (412) of the 572 existing sharing agreements[6] had some activity.[7] Of the 412 active agreements, VA provided services under 352 agreements at 108 facilities. DOD provided services under 60 agreements at 37 facilities. VA and DOD partners also reported a total of $29 million in sharing agreement reimbursements for providing health and support services in fiscal year 1998—less than 1 percent of VA and DOD's

[6]Of the total number of sharing agreements, 481 covered VA-provided services and 91 covered DOD-provided services.

[7]We considered an agreement active if the respondent provided data on the number of services actually provided, the compensation received, or some combination of these. For a listing of VA and DOD facilities with active agreements, see app. II.

combined health care budget of $34 billion.[8] Of the $29 million, VA received over $22 million from DOD and DOD received about $7 million from VA. Under 58 of the 412 active agreements, services were bartered. Of these bartered agreements, 35 were for training services, such as an agreement with VA for DOD to train its medical reserve units at VA hospitals. For 33 of the training agreements, VA provided space to DOD reserve units for training purposes; for the remaining 2, DOD provided education and training opportunities for VA. The remaining agreements were for various health and support services. Although dollar values were not generally assigned for the bartered agreements, those that did assign a value reported a total of about $775,000.

Direct medical care accounted for over 60 percent of the 412 agreements active in fiscal year 1998, with VA providing most of this care. Outpatient care accounted for most of the services exchanged, and inpatient services accounted for most of the reimbursements. Of the total reimbursements, VA and DOD provided a breakdown for $22 million: 84 percent of the reimbursements was for medical care and 16 percent was for support services.

VA and DOD also provided other health services under their sharing agreements in fiscal year 1998, including pharmacy, dental, vision, and physical therapy services. VA provided 21 other types of health services and DOD provided 18, receiving about $4 million and almost $900,000, respectively. (See tables 8 and 9 in app. III.) VA and DOD also provided a number of support services, such as transportation and laundry, with reimbursements totaling over $3.5 million. Although most of these agreements were for education and training services, laundry services accounted for most of the reimbursements for support activities. Specifically, over $2 million was collected by VA and nearly $400,000 was collected by DOD for laundry services. (See table 10 in app. III.)

[8]In January 1999, the Congressional Commission on Servicemembers and Veterans Transition Assistance issued a report on the effectiveness of programs providing benefits and services to active duty military personnel and veterans. In the commission's view, sharing activity based on the estimated revenue generated from the sharing agreements has been inadequate when compared to VA and DOD's combined health care budget.

Most Services Were Shared Under a Few Agreements; Most Revenue Was Collected by a Few Facilities

Although 72 percent of the sharing agreements were active in fiscal year 1998, the services exchanged and the revenue collected varied widely from agreement to agreement (see table 1). For example, under active agreements for inpatient care, the number of services provided by DOD ranged from 1 to 221 per agreement; reimbursements for services under an agreement ranged from about $2,000 to $1.6 million. Under active agreements for outpatient care, the number of services provided by VA ranged from 1 to more than 6,000 per agreement; reimbursements for services ranged from $90 to almost $1.7 million.

Table 1: Inpatient, Outpatient, and Ancillary Care Provided and Reimbursements Collected by VA and DOD Under Sharing Agreements, Fiscal Year 1998

			Services provided[a]		Reimbursements	
Provider	Active agreements	Facilities with active agreements	Total	Range	Total	Range
Inpatient admissions						
VA	70	34	333	1-49	$2,585,733	$352-1,437,874
DOD	16	13	556	1-221	2,905,140	1,935-1,600,000
Outpatient visits						
VA	154	53	39,202	1-6,023	5,167,051	90-1,683,537
DOD	23	12	13,438	2-8,574	433,886	506-177,330
Ancillary care procedures[b]						
VA	115	41	34,368	1-11,953	1,650,906	5-609,079
DOD	21	17	14,860	3-2,624	759,481	8-198,914

Note: Agreements may have covered more than one type of care and, therefore, would be counted more than once. Not all survey respondents provided all requested information.

[a]Actual episodes of care.

[b]These procedures include laboratory and radiology services.

Notably, we found that inpatient, outpatient, and ancillary services were provided under a few agreements or by a few facilities. Inpatient care provided under 12 active agreements at 6 VA and 6 DOD facilities accounted for 75 percent of inpatient services shared. Similarly, outpatient care provided under 19 agreements at 11 VA and 4 DOD facilities and ancillary care provided under 12 agreements at 6 VA and 6 DOD facilities accounted for 75 percent of these services. In addition, 75 percent of the total reimbursements under the active agreements was collected by 26, or 18 percent, of the 146 facilities with sharing agreements (see table 2).

Table 2: Facilities Collecting Most Reimbursements Under Sharing Agreements in Fiscal Year 1998, by Provider of Services

Provider of services	Facilities receiving services	Number of agreements	Reimbursements
VA provided			
Louisville, Ky.	Fort Knox; Navy Military Medical Support Office (MMSO); Columbus Air Force Base (AFB)	3	$2,577,783
Richmond, Va.	Fort Eustis; Fort Lee; Fort Lee Kenner Clinic; Langley AFB; DOD-wide (for spinal cord injuries)	9	2,482,830
Palo Alto, Calif.	Onizuka Air Station; Travis AFB; Army National Guard; Army Defense Finance Accounting Service; Army Camp Parks; California Medical Detachment; DOD-wide (for all medical care)	7	1,823,666
Miami, Fla.	Army 347th Reserves; Fort Sam Houston; Navy MMSO; Navy Reserve, Hialeah; Navy Clinic, Key West; Coast Guard, Norfolk, Va.	8	1,239,533
Minneapolis, Minn.	Fort Knox, Ky.; 114th Combat Army Hospital; Grand Forks AFB, N.Dak.; Army National Guard Reserve; Air Force 934th Squadron; Air National Guard 133rd Medical Squadron; Navy MMSO; Navy and Marine Reserves; Coast Guard, Norfolk, Va.	9	904,640
Brockton/West Roxbury, Mass.	Keller Army Medical Hospital, West Point; Massachusetts National Guard; Hanscom AFB; Army 399th Combat Hospital; Army Research Institute of Environmental Medicine	5	873,332
Indianapolis, Ind.	Ireland Army Hospital, Fort Knox, Ky.; Army Reserves; Army Reserves 337th Combat; Army Defense Finance Accounting Service; Navy MMSO; Navy Reserves; Wright Patterson AFB	7	847,371
Cleveland, Ohio	Military Entrance Processing Station (MEPS); Fort Knox Army Medical Activity; Ohio National Guard	3	784,811
Tomah, Wis.	Fort Knox; Air Force, Volk Field; Navy MMSO	5	750,890
Leavenworth, Kans.	Irwin Army Hospital, Fort Riley; Munson Army Hospital, Fort Leavenworth; Army Dental Clinic Command; Kansas Army National Guard; Kansas Air National Guard-190th; Kansas Air National Guard at McConnell AFB; Army Health Services; Army 4204th Reserve Hospital; Army Reserve 7211th Medical Support Unit; Army 325th Field Hospital; Navy MMSO; Coast Guard, Norfolk, Va.	14	687,866
Long Beach, Calif.	Army Command; Army National Guard; Los Angeles AFB; Navy, Port Hueneme; Navy Reserve; Navy MMSO; Coast Guard, Norfolk, Va.	7	600,369
Pittsburgh, Pa.	339th General Hospital; Army Medical Department; Navy MMSO	3	486,000

Continued

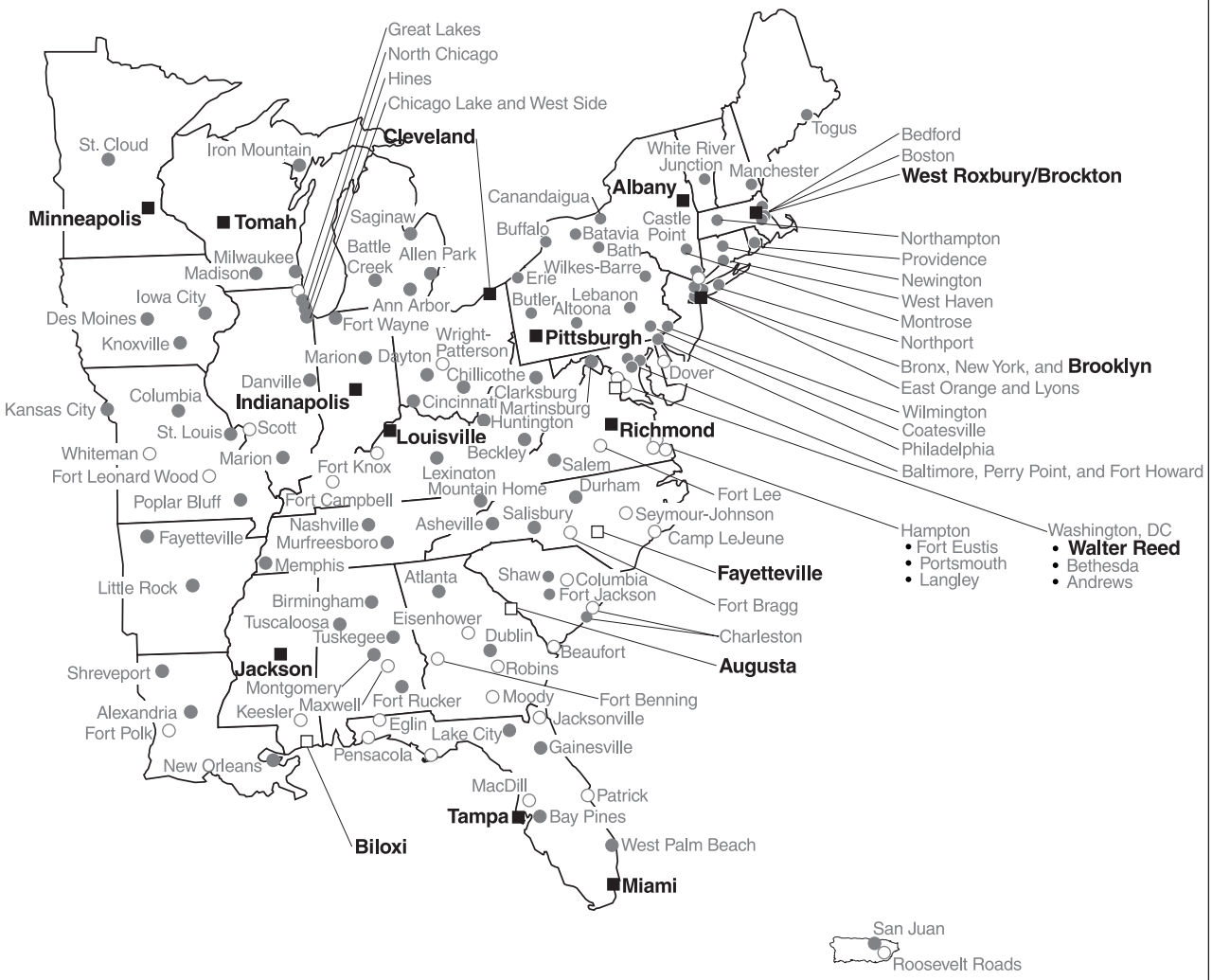
Provider of services	Facilities receiving services	Number of agreements	Reimbursements
Albany, N.Y.	Air Force 66th Medical Group; Air Force 109th Medical Group; Air Force 109th Medical Squadron; Air National Guard, Stratton; Army National Guard; 364th General Hospital; MEPS, Albany; Fort Drum; Navy Hospital, Oakland; Navy MMSO	10	447,426
Jackson, Miss.	Mississippi Air National Guard; Mississippi Army National Guard; Fort Sam Houston Army Medical Command; Army Reserve; Naval Air Station, Meridian; Navy MMSO; Jackson State University Reserve Officers Training Corps	10	411,287
North Texas VA Health Care System, Dallas, Tex.	Army, Fort Sam Houston; MEPS; Texas Army National Guard; Sheppard AFB 82nd Medical Squadron; Navy, Corpus Christi; Navy MMSO	6	404,463
South Texas Health Care System, San Antonio, Tex.	Wilford Hall Medical Center, Lackland AFB; Brooke Army Medical Center, Fort Sam Houston; Navy, Corpus Christi; Naval Reserve Fleet Hospital 21; Navy MMSO	6	352,136
Tampa, Fla.	Army Reserve 81st Command; Army Reserve Regional Support; Naval Air; Florida National Guard; Navy MMSO; Coast Guard, Norfolk, Va.	6	328,199
Brooklyn, N.Y.	Army, Fort Monmouth/Ainsworth/Patterson; Army MEPS; Navy MMSO; Coast Guard, Norfolk, Va.	5	325,356
Augusta, Ga.	Dwight David Eisenhower Army Medical Center, Fort Gordon	3	306,993
DOD provided			
Brooke Army Medical Center, San Antonio, Tex.	South Texas VAMC	3	1,677,000
Womack Army Hospital, Fort Bragg, N.C.	Fayetteville VAMC; Durham VAMC	4	839,065
Keesler AFB Medical Center, Biloxi, Miss.	Biloxi VAMC	1	586,857
Walter Reed Army Medical Center, Washington, D.C.	VA Lakeside, Chicago, Ill.; Washington, D.C., VAMC	9	557,044
Naval Hospital, Guam	Honolulu VA	1	528,393
Bassett Army Community Hospital, Fort Wainwright, Fairbanks, Alaska	Alaska VA Healthcare System	1	468,423
Madigan Army Medical Center, Tacoma, Wash.	Seattle/Puget Sound VA Health Care System	1	442,858
Total		**146**	**$21,734,591**

Continued from Previous Page

Most sharing activity measured by reimbursement occurred in the eastern portion of the country and in areas where VA and DOD facilities are in proximity to each other (see fig. 2). For example, Walter Reed Army Medical Center in Washington, D.C., received over $400,000 from VA for

providing inpatient services under three sharing agreements. For ancillary care procedures, the VAMC in Louisville, Kentucky, received over $600,000 in payments from Fort Knox under one sharing agreement—more than a third of the total reimbursements for all ancillary care services provided by VAMCs under active sharing agreements.

Figure 2: Locations of Facilities Collecting Most Reimbursements Under Sharing Agreements in Fiscal Year 1998


Great Lakes
North Chicago
Hines
Chicago Lake and West Side
Cleveland
St. Cloud
Iron Mountain
Minneapolis
Tomah
Saginaw
Battle Creek
Allen Park
Milwaukee
Madison
Iowa City
Des Moines
Knoxville
Ann Arbor
Fort Wayne
Wright-Patterson
Marion
Dayton
Danville
Indianapolis
Chillicothe
Columbia
Kansas City
Cincinnati
Clarksburg
Martinsburg
Huntington
St. Louis
Scott
Louisville
Whiteman
Marion
Beckley
Fort Leonard Wood
Fort Knox
Lexington
Poplar Bluff
Fort Campbell
Mountain Home
Nashville
Asheville
Fayetteville
Murfreesboro
Memphis
Little Rock
Atlanta
Birmingham
Tuscaloosa
Eisenhower
Tuskegee
Dublin
Shreveport
Jackson
Robins
Montgomery
Maxwell
Fort Rucker
Moody
Alexandria
Keesler
Eglin
Jacksonville
Fort Polk
Lake City
Pensacola
Gainesville
New Orleans
MacDill
Patrick
Tampa
Bay Pines
Biloxi
West Palm Beach
Miami
San Juan
Roosevelt Roads
Canandaigua
Albany
Buffalo
Batavia
Bath
Castle Point
Erie
Wilkes-Barre
Butler
Lebanon
Altoona
Pittsburgh
Dover
Richmond
Salem
Durham
Fort Lee
Salisbury
Seymour-Johnson
Camp LeJeune
Fayetteville
Shaw
Columbia
Fort Jackson
Fort Bragg
Charleston
Beaufort
Augusta
Fort Benning
Togus
White River Junction
Manchester
Bedford
Boston
West Roxbury/Brockton
Northampton
Providence
Newington
West Haven
Montrose
Northport
Bronx, New York, and Brooklyn
East Orange and Lyons
Wilmington
Coatesville
Philadelphia
Baltimore, Perry Point, and Fort Howard
Hampton
• Fort Eustis
• Portsmouth
• Langley
Washington, DC
• Walter Reed
• Bethesda
• Andrews
○ Military Medical Facility
● VA Medical Facility
□ Military Medical Facility Among the 26 VA and DOD Facilities That Generated 75% of Revenue From Sharing Agreements
■ VA Medical Facility Among the 26 VA and DOD Facilities That Generated 75% of Revenue From Sharing Agreements

Sharing Activity Under Joint Venture Agreements Also Concentrated

While sharing activity under the joint ventures was substantial—as would be expected, given the effort required to establish a joint venture—most activity was found at the two joint venture sites where local partners integrated many hospital services and administrative processes: Nevada and New Mexico. For example, in fiscal year 1998, these two joint ventures provided almost 300,000 episodes of medical care and together reported a combined cost avoidance—or savings to the government—of over $3.2 million.[9] In contrast, only about 60,000 episodes of care were provided at the remaining four joint ventures operational as of 1998, with reimbursements between these partners totaling about $21.5 million (see table 3).

Table 3: Volume of Activity at Joint Ventures by Type of Joint Venture, Fiscal Year 1998

Joint venture and partners	Facility type	Activity for fiscal year 1998
Integrated		
Alaska: Elmendorf AFB, 3rd Medical Group and Anchorage VAMC	Construction of 110-bed hospital for VA and DOD patients in 1999, with 10 intensive care unit beds staffed by VA and 25 surgical beds staffed by Air Force.	[a]
Nevada: Nellis AFB and VA Southern Nevada Health Care System, Las Vegas	Begun in 1991, construction of 114-bed hospital for Air Force and VA patients; completed in 1994.	VA reported $2 million in cost avoidance. The facility provided VA and DOD beneficiaries a total of 17,961 inpatient days (12,501 VA and 5,460 Air Force) and 198,916 outpatient visits (158 VA and 198,758 Air Force). (Note: VA has separate ambulatory outpatient facilities.)
New Mexico: Kirtland AFB and Albuquerque VAMC	Two efforts have been completed: —integrated existing 375-bed hospital in 1987 and —new Air Force outpatient clinic built in 1989.	VA and DOD reported in excess of $1.2 million in cost avoidance. The facility provided VA and DOD beneficiaries a total of 48,044 inpatient days (47,025 VA and 1,019 Air Force) and 15,894 outpatient visits (9,000 VA and 6,894 Air Force).
Shared space		
California: David Grant Medical Center, Air Force 60th Medical Group, and VA Northern California Health Care System[b]	Begun in 1993, 468-bed Air Force hospital remodeled to accommodate VA patients.	VA reimbursed the DOD medical center $7.2 million for 1,691 inpatient care admissions, 5,768 outpatient visits, 274 ancillary services, and 524 radiation and hyperbarics services.[c]

Continued

[9]Because these integrated joint ventures operate seamlessly, they collect financial information based on cost avoidance rather than the total reimbursements made to each other.

Joint venture and partners	Facility type	Activity for fiscal year 1998
Florida: Key West Naval Branch Clinic (Jacksonville Naval Hospital) and Miami VAMC	Initiative begun in 1994; construction of outpatient clinic completed January 2000, with VA and Navy sharing space.	[d]
Hawaii: Tripler Army Medical Center and Honolulu VAMC	Three efforts have been phased in since 1991: —VA psychiatric ward in Army hospital opened in 1994, —construction of 60-bed center for aging completed in 1997, and —construction of ambulatory clinic will be completed in May 2000.	VA reimbursed the DOD medical center $9.4 million for 1,105 inpatient admissions, 10,704 outpatient visits, and over 6,200 consultations.
VA facility constructed on DOD property		
Oklahoma: Reynolds Army Community Hospital at Fort Sill and Oklahoma City VAMC	Initiative begun in 1990; construction of VA outpatient clinic adjacent to Army Hospital completed in 1995.	VA reimbursed the DOD hospital $201,291 for radiology, laboratory, custodial, and food services.
Texas: William Beaumont Army Medical Center at Fort Bliss and El Paso VAMC	Initiative begun in 1987; construction of ambulatory care center adjacent to the Army hospital completed in 1995.	VA reimbursed the DOD medical center $4.7 million for 3,585 inpatient admissions, 22,559 outpatient visits, 1,009 ancillary procedures, and support services (6 security guards).

Continued from Previous Page

[a]The hospital opened in May 1999. It will track data on bed occupancy, laboratory procedures, radiology, and MRI (magnetic resonance imaging) tests, and emergency room visits by VA and DOD patients.

[b]Includes outpatient clinics at Chico, Fairfield, Mather, Marc Island, Martinez, Oakland, and Redding.

[c]Hyperbarics is the administration of oxygen under increased pressure while the patient is in an airtight chamber. These treatment facilities—which have been used to treat carbon monoxide poisoning, gas gangrene, burns, smoke inhalation, and decompression sickness (bends)—are expensive to build and operate and are needed by only a small number of patients.

[d]The clinic opened in January 2000; therefore, measurable activity has not occurred.

Participation Among Partners in National Sharing Initiatives Is Minimal

We found little participation among local sharing partners in 10 initiatives introduced by the VA/DOD Executive Council since its inception—even 2 that have been fully developed. The first—a Military and Veterans Health Coordination Board established by the President in November 1998—works through the VA/DOD Executive Council to conduct studies and research and provide ongoing direction to ensure national coordination among VA, DOD, and the Department of Health and Human Services on military and veterans health matters. Even though this initiative provides many opportunities for local involvement, we found little evidence of local participation. The second fully developed council initiative was implemented in September 1999 when DOD issued procedures for conducting joint disability discharge physical examinations to do away with duplicate examinations of military personnel applying for a service-connected disability. By requiring only one examination, the program is expected to eliminate costly redundancies in physical examinations and

accelerate the processing of disability claims. Nevertheless, only 21 VA facilities and 18 DOD facilities reported participating in the joint disability discharge initiative.

Few survey respondents reported participation in the council's remaining eight initiatives, which are in various stages of development. These also have direct implications for local sharing:

- *Cost reimbursement*: To create a uniform cost-reimbursement methodology for sharing health resources.
- *Medical/surgical supply acquisition*: To pursue joint clinical and pharmacy functions and to eliminate redundancies in reviews, contracts, prescribing guidelines, and utilization management.
- *Specialized treatment system/centers of excellence*: To use existing VA and DOD capability for specialized services and to combine programs to reduce infrastructure overlaps, such as designating the Albuquerque VAMC as the national center for neuroimaging for both VA and DOD.
- *Information management and technology*: To encourage VA and DOD to collaborate on technical standards for developing systems to jointly manage information such as patient medical records.
- *Medical technology assessments*: To examine VA's and DOD's acquisition and use of medical technology to avoid duplicate purchases and better use existing equipment.
- *Patient safety*: To develop a process for sharing lessons learned on patient safety and develop best practices to reduce preventable adverse drug events.
- *Clinical practice guidelines*: To develop VA/DOD evidence-based guidelines for disease treatment to improve patient outcomes.
- *Joint congressional interaction*: To improve communication between DOD and VA congressional contacts on the extent of interdepartmental sharing.

Some Sharing Occurs Under Authority Other Than the Sharing Act

Of the survey respondents, 13 VAMCs and 22 MTFs reported that they had entered into one or more joint purchasing arrangements in fiscal year 1998 to purchase pharmaceuticals, laboratory services and supplies, medical supplies and equipment, and other types of services (see table 4). For example, the Madigan Army Medical Center in Tacoma, Washington, and the Roosevelt Roads Naval Hospital in Puerto Rico reported to us that they use VA's Subsistence Prime Vendor Program to jointly purchase food and supplies. Other joint arrangements involve several VA and DOD facilities.

Table 4: Joint Purchasing Arrangements Among VA and DOD Facilities Participating in Local Sharing Agreements, Fiscal Year 1998

Purchasing arrangement	Number of VA facilities	Number of DOD facilities
Pharmaceuticals	2	8
Laboratory services/supplies	8	11
Medical supplies	6	7
Medical equipment	2	11
Other services	4	22

Some respondents reported savings as a result of their joint purchasing activities. For example, under one medical purchasing contract—involving three VAMCs and nine DOD facilities—VA and DOD expect cost savings of $4.5 million over the 5-year contract period. VA and DOD also reported that their joint purchasing contract for medical transcription services at the VAMC and Naval Hospital in San Diego saved over $200,000 in fiscal year 1999; over the 5-year contract, they anticipate saving over $1 million.

VA and DOD Report Barriers to and Emerging Problems for the Sharing Program

Local VA and DOD officials identified a number of barriers that could jeopardize current sharing agreements or impede further sharing of health care resources. The barrier identified most often by DOD was the geographic distance between the VA and DOD partner facilities, making it difficult for them to rely on each other to provide services and reasonable access to their beneficiaries, while VA has found that its ability to provide services to DOD beneficiaries has been limited by VA beneficiaries' full utilization of its VAMCs. Survey respondents continue to identify two long-standing barriers—policies governing reimbursement and budget and processes for approving sharing agreements—which we have previously reported on.[10]

Significant transformations in VA's and DOD's health care delivery systems have also affected how VA and DOD share resources. For example, both agencies are purchasing more health care services from private providers and implementing managed care principles. In response, VA and DOD have

[10]GAO/HRD-78-54, June 14, 1978, and GAO/HRD-88-51, Mar. 1, 1988.

each developed service regions that have operational control over providers and facilities, including hospitals. Among the barriers identified, recent policies and guidance governing DOD's managed care program, TRICARE, may have the most significant implications for sharing because they have resulted in confusion among the military Surgeons General and local VA and DOD partners about what can be shared and how that sharing can occur.

Reimbursement and Budgeting Policies and Processes for Approving Agreements Are Long-Standing Barriers

Since 1978, we have reported that certain reimbursement and budgeting policies discouraged sharing between VA and DOD. Specifically, we found that due to a lack of understanding among local officials, some VA and DOD hospitals set reimbursement rates at total costs rather than at incremental costs. However, recovering incremental costs would give providers more incentive to share because recovering these costs increases the facilities' revenues and also decreases per-unit costs for the remainder of the providers' patients. We have also reported that MTFs' incentive to share was reduced because they submit reimbursements received for services provided under sharing agreements to a centralized DOD account, instead of keeping the reimbursements for their own use, as VAMCs do.

Although certain actions have been taken to address these two barriers, they still exist. To address the first barrier, the VA/DOD Executive Council Healthcare Financial Management Committee approved in December 1997 guiding principles and recommendations for costing of services to provide local flexibility to negotiate rates that are beneficial to both VA and DOD. Subsequently, each branch of the service drafted implementing guidelines. However, some survey respondents reported that, as of August 1999, these reimbursement issues remained. For example, VA guidance stresses using incremental costs for sharing agreements, but some VAMCs reported charging the total cost of providing care to DOD beneficiaries, including overhead costs, such as administration. While some MTFs bill at less than total cost for care provided to VA beneficiaries, others bill at the total cost. Regarding the second barrier, the council believes that local officials may be misinterpreting DOD's guidelines on the authority to retain reimbursements from VA partners and has recommended better articulation of these guidelines. According to local DOD officials, some MTFs still deposit these funds into a centrally managed DOD account, although DOD guidance states that MTFs can keep funds received from sharing agreements. In our survey, a number of respondents specifically noted that flexibility to negotiate rates and clarification of reimbursement guidelines would provide a greater incentive to share.

A related barrier, according some VA and DOD local officials, centers on "dual eligible beneficiaries"—retired military who are also veterans. These beneficiaries who seek care under a sharing agreement have dual access to care—based on space available at MTFs and VA eligibility status. Each agency tries to shift to the other the responsibility for treatment and payment, making collaboration on sharing agreements for this population particularly difficult.

Other long-standing barriers VAMCs and MTFs reported relate to VA's and DOD's budgeting processes. For example, Air Force officials at both the Nevada and New Mexico joint ventures told us that their budget requests for medical personnel and operations and maintenance funding only take into account the DOD patient load, even though, as an integrated joint venture site, the Air Force facilities treat significant numbers of VA patients. An official at the Nevada joint venture believes that, as a result of this restriction, the facility's staffing levels—including those for doctors and technicians—were reduced in fiscal year 1999 and, consequently, the facility's capacity to serve veterans was also reduced. VA's and DOD's budgeting also encourages local facilities to keep beneficiaries within their own system. For example, a VAMC might transfer a VA patient to another VAMC to avoid having to use its funds to reimburse the DOD partner—even though the care may be less costly at the DOD partner facility and provide better patient access.

Thirty-one percent of VA survey respondents and 25 percent of DOD respondents also cited the process for approving sharing agreements as a barrier to sharing. Local VAMCs generally have the authority to approve their participation in sharing opportunities that they have identified. Once agreements have been reached locally, VA headquarters gives approval for entry into the sharing database and grants local officials program oversight. According to VA headquarters' officials, this approval process has been expedited and now is completed within 3 work days. MTFs, on the other hand, must receive approval from DOD headquarters to participate. According to local DOD officials, this requirement prolongs the process and has resulted in some agreements not being entered into. Some local DOD officials indicated that such experiences have discouraged them from seeking other potential sharing arrangements.

Changing Health Care Delivery Systems Pose New Challenges to the Sharing Program

Over the past 2 decades, changes in beneficiary populations, resources, and the health care environment have significantly influenced VA's and DOD's health care delivery systems and how the two agencies share health resources. Since 1980, the veteran population has declined from more than 30 million veterans to about 26 million in 1998. Barring a buildup of military forces, the veteran population is expected to continue to decline—VA estimates that the number of veterans will drop to 16 million by 2020. At the same time, however, the number of veterans aged 85 and older—a population frequently requiring nursing home care—has been projected to increase from about 150,000 in 1990 to over 1 million by 2010. DOD's beneficiary population is also changing. While the number of active duty personnel is declining, the number of military retirees is increasing as is the number of dependents. Over the past several years, DOD and VA resources have also changed. For example, DOD closed one-third of its MTFs, and VA has consolidated a number of its health care facilities.

To respond to these changes, VA and DOD have made significant changes in their health care systems, mainly adopting managed care principles and shifting care from inpatient to outpatient treatment. In October 1995, VA began to transform its hospital-based health care delivery system into a community-based system. VA developed 22 Veterans Integrated Service Networks (VISN)—geographic service areas defined by patient populations, referral patterns, and facility locations. Each VISN has operational control over and responsibility for a capitated budget for all service providers and patient care facilities, including hospitals. In addition to purchasing from the private sector some services that VA historically provided, VISNs are forming alliances with neighboring VA medical facilities, entering sharing agreements with other government providers, and purchasing services directly from the private sector. Over a 3-year period ending fiscal year 1998, VA reduced its inpatient workload by 38 percent and bed days of care per 1,000 veterans by 47 percent, resulting in a reduction of more than 20,000 hospital beds and consolidation of numerous administrative and clinical services. VA needs to continue with its efforts to realign its current assets.

DOD's health care system has undergone a similar transformation. In March 1995, DOD established its managed health care program, TRICARE, and created 12 service regions, each with a capitated budget primarily based on the total number of beneficiaries in the region. Under TRICARE,

beneficiaries can choose one of three program options:[11] TRICARE Prime, similar to a health maintenance organization; TRICARE Extra, similar to a preferred provider organization; and TRICARE Standard, a fee-for-service benefit intended to replace CHAMPUS.[12] In October 1999, DOD implemented TRICARE Prime Remote to serve active duty personnel at locations 50 miles or more from an MTF. Each TRICARE service region is administered by a lead agent who coordinates the health efforts of the three military departments and is responsible for ensuring that the provider network is adequate. Through competitive bid procedures, DOD contracts with private health care companies for services that DOD facilities are unable to provide. These regionwide contracts with provider networks represent a significant change in the delivery of DOD health care.

DOD Policy May Eliminate Local Sharing of Direct Medical Care

A number of VA and DOD officials, including each service's Surgeon General, stated that TRICARE has the potential to limit the services VA provides under the sharing program. In response to a DOD legal opinion stating that local sharing agreements for direct medical care represent competing networks with TRICARE contractors, DOD issued a policy memorandum in May 1999 that, in effect, nullifies these agreements.[13] According to the legal opinion, MTFs are required to refer DOD beneficiaries to TRICARE network providers for health care when such care is not available at the MTF, and referring a beneficiary to a VAMC partner violates the TRICARE contract unless the VAMC is a member of the network. All five TRICARE contractors told us that VA sharing agreements have had little effect on their current workload and profit. While the policy still allows sharing for support services, it calls into question all of the local sharing agreements in which VA provides direct medical care, which compose about 80 percent of the services covered under the agreements that were reported to us as active. For example, with the recent rollout of TRICARE Prime Remote, more than 100 active agreements where VA provides medical care to military beneficiaries located 50 miles or more from an MTF could effectively be eliminated.

[11]A fourth program—TRICARE Senior Prime, a managed care option for certain beneficiaries age 65 and older—is currently in the demonstration phase.

[12]CHAMPUS finances private sector care for dependents of active duty members, retirees and their dependents, and survivors. The program is still in effect.

[13]The opinion was written to clarify language in TRICARE contracts covering three regions (I, II, and V); presumably, sharing for medical care does not violate the TRICARE contracts in the other regions.

According to DOD policy, TRICARE contractors are encouraged to include VA health care facilities in their networks, as authorized under the Veterans' Health Care Eligibility Reform Act of 1996.[14] As of September 1999, DOD reported that almost 80 percent (or 137) of 172 VAMCs were TRICARE subcontractors. However, among VA survey respondents, only 53 percent reported being TRICARE contractors in fiscal year 1998, while 44 percent indicated providing some level of service under TRICARE. In addition, VA officials believe that, as network providers, VAMCs will not be used as extensively as they were under the sharing agreements because they will be among many other providers from which beneficiaries can choose. The use of VA providers under TRICARE may be most extensive in remote locations, as the five TRICARE contractors told us that they rely on subcontracts with VA in these locations to ensure an adequate network.

TRICARE Payment Practices May Discourage Future Sharing

On October 1, 1999—subsequent to the administration of our survey—DOD issued a policy that transfers funding and payment responsibility for all MTF-referred care—or supplemental care—from the MTFs to TRICARE support contractors. VA officials told us that because this new policy went into effect, VA sharing partners have been paid late, have received payments for services provided under sharing agreements at less than the sharing agreement negotiated rate, or have not received payment at all. These payment problems are the result of VA's and the TRICARE contractors' different billing processes. For sharing agreements, VA submits one bill for all medical and professional services, whereas TRICARE requires itemized bills for each service. Therefore, when TRICARE support contractors receive bills for sharing agreements, they often reimburse for only one service, resulting in VA's not getting reimbursed for a number of the services it provided. According to VA officials, the new policy has negatively affected the current sharing agreements and may become a disincentive to future sharing. DOD officials told us that they are aware of the billing and reimbursement problems that VA partners are encountering under the new policy. However, DOD has not described how or when it will resolve this issue.

[14]P.L. 104-262 sec. 302(a). The act expanded the authority for entering into sharing agreements between VA's and DOD's managed care contractors.

VA and DOD Data on Sharing Not Adequate to Assess Program Progress

Since 1987, VA and DOD have reported annually to the Congress on the status of the sharing program, as required under the Sharing Act. The reports are developed using information from the VA/DOD Federal Health Care Resources Sharing Database, which is maintained by VA. While the annual reports show growth in sharing, this growth is based on the number of agreements entered into and the range of services they cover. This measure is inadequate for determining program status because it does not reflect actual sharing activity through the volume of services provided and reimbursements collected. Although we collected such information through our survey, without comparable historical data, program progress cannot be determined. In addition, the information in the joint database is incomplete and inaccurate.

VA/DOD Database Does Not Capture Actual Volume of Sharing Activity

In 1984, VA and DOD reported to the Congress that there was a combined total of 102 VA and DOD facilities with local sharing agreements.[15] By 1994, the number of facilities with sharing agreements totaled 284. For fiscal year 1998, the most recent year for which the annual report was issued,[16] VA and DOD claimed significant growth in sharing, stating that virtually all VAMCs were involved in sharing agreements with virtually all MTFs. VA and DOD also claimed growth in the number of services covered under these agreements. In 1987, they reported that 1,387 services were covered; by 1998, this number had increased to 10,586 services,[17] including those covered under TRICARE contracts.[18] Program results, however, cannot be measured by increases in the number of sharing agreements and the number of services covered. Such numbers indicate only the potential for sharing, not the actual volume of services shared. Without measuring the actual activity—that is, the volume of services exchanged and the

[15]VA and DOD did not begin reporting the total number of agreements until fiscal year 1992.

[16]The fiscal year 1999 report was under review at the time of our work.

[17]The number of services appears high because VA and DOD count each service listed for each agreement.

[18]Although not included in the annual sharing report to Congress, VA financial records beginning in 1990 track the total revenue VA received from sharing agreements and the revenue it pays to DOD for services it provides VA. In 1990, VA collections for sharing agreements totaled $23,013,257; payments to DOD totaled $2,916,528. In 1999, VA collections for sharing agreements totaled $32,194,216, and payments to DOD totaled $23,853,957. According to VA officials, the increase in VA payments to DOD can be attributed to the joint venture locations where DOD is the host.

reimbursements collected or costs avoided—VA and DOD's claims of growth in the sharing program can be misleading, as the numbers suggest that more sharing is occurring than may be the case.

VA and DOD have also provided in their annual reports to the Congress a general description of the eight joint venture agreements. However, as with the local sharing agreements, the actual activity at the joint venture sites is not measured, nor is the progress of the 10 national sharing initiatives. Collaborative activities occurring under authority other than the Sharing Act are also not reported. Although VA and DOD are not required to report on activities occurring outside the act, the full extent of sharing cannot be determined without capturing such information.

Information Inaccurate Due to Database Weaknesses

Of the 355 VA and DOD facilities that responded to our survey and were listed as a sharing partner in the VA/DOD sharing database as of April 1999, 83 (64 DOD facilities and 19 VA facilities) told us that they do not participate in sharing agreements—a discrepancy that indicates the database overstated the number of partners by 31 percent. We also found discrepancies between the number of sharing agreements in the VA/DOD database and the number of agreements that facilities reported to us during each of our site visits. In some cases, the number of agreements was understated in the database. For example, an agreement between the Southern Nevada Health Care System and the Air Force hospital in Las Vegas, Nevada, was not listed in the sharing database. In other cases, the number of agreements was overstated. For example, the sharing database listed 17 agreements between the New Mexico VAMC and Kirtland AFB, while documentation provided by VA and DOD officials at these sites listed only 8 agreements.

We found several weaknesses in the management of the database that could account for some of these discrepancies:

- Expired and terminated agreements are deleted from the database only once a year, according to VA database managers. Therefore, many agreements may be listed as active when they are not.
- New and terminated agreements are not consistently reported by sharing partners to VA database managers. For example, we found that 21 VAMCs did not submit the required forms for reporting new sharing agreements to VA for inclusion in the database.
- Education and training agreements are underreported because some sharing partners do not know that they are required to report them,

although VA and DOD's reporting policy clearly requires that these agreements be included.

Conclusions

VA and DOD sharing partners generally believe the sharing program has yielded benefits in both dollar savings and qualitative gains, illustrating what can be achieved when the two agencies work together. Although the benefits have not been fully quantified, it seems worthwhile to continue to pursue opportunities to share resources where excess capacity and cost advantages exist, consistent with the law. However, reductions in excess capacity for certain services resulting from various efficiency and right-sizing initiatives, along with extensive contracting for services, especially through TRICARE, have changed the environment in which resource sharing occurs. In particular, DOD's policy regarding referrals under TRICARE has, in effect, thrown the resource sharing program into turmoil and put VA and DOD at odds on how to make the most effective use of excess resources where they still exist. Additionally, ongoing changes within VA's and DOD's health care systems—such as the implementation of managed care, the shift from inpatient to outpatient delivery settings, and projected decreases in patient populations—have altered and will continue to change the scope and magnitude of sharing opportunities.

Under these circumstances, the criteria and conditions that make resource sharing a cost-effective option for the federal government—not just VA or DOD alone—need to be reviewed and the strategies for sharing rethought. To determine the most appropriate courses of action, several questions require answers. For example, does VAMC treatment of TRICARE patients result in lower overall cost for the government than contracting with private providers? Would requiring VAMCs to be considered the equivalent of MTFs yield a more efficient and cost-effective way to provide needed care to beneficiaries? Are there additional joint contracting opportunities that would provide needed services to VA's and DOD's respective populations more cost-effectively than each agency providing such care itself? Also, if sharing is to be optimized, can significant and long-standing barriers be overcome, such as the need for processes that facilitate billing, reimbursement, budgeting, and timely approval of sharing agreements? VA and DOD need to work in concert to answer such questions. However, reaching timely agreement could prove difficult given the different business models VA and DOD are using to provide health care services to their beneficiaries. Therefore, we are advising that, in the event such an agreement is not reached, it may be necessary for the Congress to provide specific guidance to both VA and DOD, clarifying the criteria, conditions,

and expectations for VA and DOD collaboration. In addition, we have identified specific steps each agency needs to take to stabilize the current sharing program until a reassessment of its direction, goals, structure, and criteria can be made.

Recommendations to the Secretaries of Veterans Affairs and Defense

The Secretaries of VA and DOD should jointly assess how best to achieve the goals of health resource sharing, considering the changes that have occurred over the last decade in the VA and DOD health care systems and the populations they serve. This assessment should include a determination of the most cost-effective means of providing care to beneficiaries from the federal government's perspective—not just from the perspective of either VA or DOD. As part of this assessment, DOD and VA should determine the appropriate mix of purchasing care directly from contractors or providing care directly through their own systems, including medical sharing opportunities, by identifying current and expected excess capacities.

In addition, to the extent sharing opportunities and potential are identified, we recommend that the agencies jointly address the barriers that have impeded sharing and collaboration, by establishing procedures to accommodate each other's budgeting and resources management functions as well as facilitate timely billing, reimbursement, and agreement approval.

Finally, to increase the usefulness of the joint VA/DOD database as a means for assessing and reporting sharing progress to the Congress, we recommend that the Secretaries direct, respectively, the Under Secretary for Health and the Assistant Secretary of Defense (Health Affairs) to include in the joint database

- the volume and types of services provided, reimbursements collected, and costs avoided under local and joint venture sharing agreements between VA and DOD facilities by having facilities report this activity to the medical sharing office and
- similar information on the progress and activity occurring under national initiatives and other sharing activities authorized outside of the Sharing Act.

Recommendation to the Secretary of Defense

To provide stability to the current sharing program while DOD and VA reassess how best to achieve the goals of resource sharing legislation, we recommend that the Secretary direct the Assistant Secretary (Health Affairs) to review and clarify, for each category of beneficiary, DOD's policy on the extent to which direct medical sharing is permitted with VA, including whether the current sharing agreements are still in effect and under what circumstances DOD requires VA to be part of the TRICARE network in order to share resources; provide clear guidance to contractors on how to process claims to ensure timely reimbursements; and take a more proactive role in managing the joint VA/DOD sharing database.

Recommendation to the Secretary of Veterans Affairs

To increase the attractiveness of VAMCs as cost-effective providers of services to DOD, we recommend that the Secretary of VA direct the Under Secretary for Health to ensure that VAMCs follow VA's guidelines and charge incremental costs rather than total costs under sharing agreements.

Matters for Congressional Consideration

As the health care environment in which VA and DOD share resources continues to evolve, VA and DOD will likely continue to be challenged in their collaborations on how best to make effective use of excess federal health care resources. If the two agencies are unable to resolve their differences in a reasonable amount of time, the Congress should consider providing direction and guidance that clarifies the criteria, conditions, roles, and expectations for VA and DOD collaboration.

Agency Comments and Our Evaluation

We provided VA and DOD a draft of this report for comment (see apps. IV and V, respectively). Generally, each agency agrees that there are opportunities to improve the administration of the sharing program. However, regarding our recommendation to jointly reassess how best to achieve the goals of health resources sharing, the two agencies responded very differently. VA did not concur with our recommendation. It stated that our draft report seriously downplayed DOD's resistance to cooperative federal sharing activity and that it has taken strong actions to remove virtually all barriers to comprehensive sharing. VA did comment, though, that it would continue to seek ways to work cooperatively with DOD and to actively participate with other program officials in reassessing and implementing improved program goals. DOD, on the other hand, agreed with our recommendation and stated that a Health Care Sharing Work

Group is being created under the Executive Council to facilitate sharing and resolve sharing-related issues. DOD's and VA's widely different responses to our recommendation, in our opinion, typifies the current chasm between them on sharing-related matters and clearly points to the need for the two agencies to try harder to resolve their differences. Therefore, we stand by our recommendation that VA and DOD work together to rethink how they can best meet the goals of sharing and have added to the recommendation some of the areas that VA and DOD should consider in this collaboration. Further, because VA's and DOD's comments indicate that they may be unwilling or unable to work together to address our recommendation in a timely manner, we have added a matter for congressional consideration to provide VA and DOD direction and guidance if the agencies fail to act within a reasonable time.

Regarding TRICARE, VA believes that our report should point out that DOD's policy effectively prohibits VAMCs and MTFs from sharing for direct medical care. However, DOD commented that the policy does not prohibit such sharing—which seems to contradict its legal opinion on TRICARE. Our draft report described the implications of the policy on sharing, and we have added material to underscore the confusion that surrounds the interpretation and implementation of this policy. In response to our recommendation to reassess its TRICARE policy on referring patients to VAMCs, DOD said that the policy requires clarification. However, DOD did not indicate that it would reassess the policy in light of the effects it has had on sharing. Therefore, we expanded our recommendations to specifically call for DOD to review and clarify (1) the extent to which direct medical care is permitted with VA for all categories of beneficiaries, (2) the circumstances under which VA must be a part of the TRICARE network, and (3) whether current sharing agreements remain in effect.

Regarding our recommendation addressed to VA to increase the usefulness of the VA/DOD sharing database by expanding the data it captures, VA commented that the database was not designed to be used as a broad evaluative tool but, instead, was created to develop data for the annual report to the Congress, as required under the law. VA's statement implies that the intent of the law for reporting to the Congress is not to provide information that can be used to assess the effects and progress of the sharing program. We disagree and believe that in requiring VA and DOD to report annually on the sharing program, the Congress is seeking information that will help it gauge, over time, how the agencies are responding to the mandate that they seek opportunities to share federal health care resources and thereby hold down federal costs.

VA also had concerns regarding the effort it believes will be required to implement our recommendation to gather more comprehensive data on sharing activity. We believe, however, that the approach VA outlined in its comments is more than is needed to improve the database and that VA misinterpreted the intent of our recommendation. For example, VA states that to measure the actual exchange of services between local and joint venture sharing partners, it would need to use clinical workload data and ensure compatibility with DOD's workload data. However, VA and DOD could collect data on the actual exchange of services through other less resource-intensive and costly undertakings, such as a simple reporting of activity by each VA and DOD facility to show the number and types of services provided. We collected this information on sharing activity through our survey. VA also commented that, in addition to having sole administrative responsibility for the database, it alone has borne the costs for two system upgrades. To the extent that VA is concerned about this, it should work out an agreement with DOD to share costs.

VA also disagreed that VAMCs generally charge the full cost of providing care to DOD beneficiaries and noted that its guidance stresses incremental costs. In response, we discuss VA's guidance regarding incremental costs but note that some VAMCs reported to us that they charged the total cost of providing care to DOD beneficiaries, including overhead costs.

VA also expressed concern that certain information on the sharing program was not included in our draft report. For example, VA noted that it was working with DOD to develop joint telemedicine standards. In our report, we highlighted the VA/DOD Executive Council's 10 initiatives; telemedicine is part of medical technology assessment. In addition, our survey asked VA and DOD partners to provide information on sharing activities occurring under authority other than the Sharing Act; none of the respondents reported participating in the telemedicine effort. Further, VA and DOD's most recent annual report to the Congress does not discuss telemedicine. VA also commented that we did not discuss MTF use of VA's Subsistence Prime Vendor Program. Our draft cited this contract as an example of a joint purchasing arrangement; we revised the report to name the program. Last, VA commented that there are many sharing agreements for dental services; we reported this information in appendix III of the draft report submitted to VA (see table 8).

VA and DOD also provided technical comments, which we incorporated where appropriate.

Copies of this report are being sent to the Honorable Togo West, Secretary of Veterans Affairs; the Honorable William S. Cohen, Secretary of Defense; and other interested parties. We will also make copies available to other upon request. Please contact me at (202) 512-7101 if you or your staff have any questions concerning this report. Staff contacts and other contributors are listed in appendix VI.

Cynthia Bascetta
Associate Director, Veterans' Affairs and
Military Health Care Issues

Scope and Methodology

We spoke with VA and DOD headquarters officials and obtained information through a mail survey sent to every VA medical facility and DOD unit identified by the agencies as participating in local sharing agreements. We also conducted site visits to VA and DOD medical facilities participating in local sharing agreements in Florida (Miami VAMC and the Jacksonville Naval Hospital Branch Clinic in Key West), Illinois (North Chicago VAMC and Great Lakes Naval Hospital), and Virginia (Hampton VAMC, Richmond VAMC, and Fort Lee Kenner Clinic). We also met with VA and DOD officials at three joint venture sites: Florida (Miami VAMC and Jacksonville Naval Hospital Branch Clinic in Key West), Nevada (Nellis AFB Michael O'Callaghan Federal Hospital and Las Vegas VA Outpatient Clinic), and New Mexico (Albuquerque VAMC and Kirtland AFB); we conducted telephone interviews with officials at the remaining joint ventures in Alaska (Anchorage VAMC and Elmendorf AFB), California (Air Force 60th Medical Group at David Grant Medical Center and VA Northern California Health Care System), Hawaii (Honolulu VA Outpatient Clinic and Tripler Army Medical Center), Oklahoma (VAMC Oklahoma City and Reynolds Army Community Hospital at Fort Sill), and Texas (El Paso VAMC and William Beaumont Army Medical Center).

In addition, we analyzed information maintained in the VA/DOD Federal Health Care Resources Sharing Database, which is used to develop the agencies' joint annual reports to the Congress. We also interviewed officials from DOD's five managed care contractors (Anthem Alliance for Health, Foundation Health Federal Services, Humana Military Health Care Services, Sierra Military Health Services, and TriWest Health Care Alliance) to obtain their views on any effect DOD's TRICARE managed care program may have on the sharing agreements. We also conducted a literature search to obtain background information and reviewed previous GAO studies conducted on VA/DOD sharing in the past.

Survey Development

To develop questions used in the survey, we spoke with VA and DOD officials about sharing agreements under Public Law 97-174. Our questions focused on services provided or received, experiences encountered with the agreements, and other types of sharing activities such as national initiatives or joint purchasing arrangements.

Before mailing our questionnaire, we pretested it with VA and DOD officials knowledgeable about sharing activities at four VA medical

facilities and three DOD facilities. We refined the questionnaire in response to their comments to help ensure that the potential respondents could provide the information requested and that our questions were fair, relevant, unbiased, and answerable with readily available information.

Survey Distribution, Response Rates, and Analysis

To identify survey recipients, we used the VA/DOD Federal Health Care Resources Sharing Database. As of April 1999, the database indicated that 547 VA and DOD facilities had at least one VA/DOD sharing agreement and that the number of agreements totaled 803. We adjusted our population to 447 (154 VA and 293 DOD) facilities, omitting the 8 joint venture partners, 11 duplicate partners in the VA/DOD database, 6 inactivated units, and 75 facilities where DOD was unable to provide mailing addresses.[1]

In identifying facilities, we frequently could not determine from the information in the database which branch of service the DOD partner represented. For example, a partner may have been listed as "10th Medical Group." To determine the specific branch of service for each DOD partner, we met with VA officials who provided us information from either their knowledge of the DOD unit's participation or from DOD documents. Identifying reserve and national guard units was also difficult, particularly since DOD points of contact are not included in the database. We mailed the questionnaires to the 154 VAMC directors in June 1999 and to the 293 individual DOD unit commanders in June and July 1999. We conducted two follow-up mailings and telephone follow-ups to nonrespondents.

We ended our data collection in November 1999. To adjust for the consolidation and integration of some facilities,[2] the closing of some facilities, and duplicate submissions, we further reduced our population by 33 facilities. Our final adjusted population was 414 facilities (138 VA facilities and 276 DOD facilities), with a response rate of 100 percent for VA

[1]We did not mail surveys to the eight joint ventures because sharing activity is assumed; we did interview officials at all the joint ventures. In addition, we did not mail a survey to the Navy's Military Medical Support Office (MMSO), Great Lakes, Illinois, because it is a fiscal intermediary for the Navy and Marine Corps and is neither a receiver nor provider of services. We did interview MMSO officials and obtained information on the more than 100 sharing agreements that it oversees.

[2]A number of VA hospitals have recently integrated and developed one management team to oversee numerous hospitals within a geographic service area. In 15 cases, the integrated facility completed one questionnaire for all the hospitals within the integrated system.

facilities and 79 percent for DOD facilities. (See table 5 for individual DOD services' response rates.)

Table 5: DOD Services' Response Rates

	Adjusted population	Responses	Response rate
Army	116	83	72%
Air Force	75	64	85
Coast Guard	25	24	96
Navy	60	46	77
Total	**276**	**217**	**79%**

Of the 355 facilities that responded, 272 indicated that they were a provider or receiver of medical or support services and 83 reported that they did not participate in sharing agreements. Therefore, we restricted our analysis to the 272 respondents who indicated that they were a provider or a receiver of shared medical or support services. These responding facilities participated in 572 agreements.

Facilities With Active Agreements

In fiscal year 1998, 108 VA and 37 DOD facilities had active agreements. Table 6 lists the 108 VA facilities by VA's 22 Veterans Integrated Service Network (VISN) areas—geographic service areas defined by patient populations, referral patterns, and facility locations; table 7 lists the 37 DOD facilities by branch of service.

Table 6: VA Facilities With Active Local Sharing Agreements and Their Locations

Facility	City and state
VISN 1	
Edith Nourse Rogers Memorial VA Hospital	Bedford, Mass.
Boston VA Medical Center	Boston, Mass.
Brockton/West Roxbury VA Medical Center	Brockton, Mass.
Northampton VA Medical Center	Northampton, Mass.
Manchester VA Medical Center	Manchester, N.H.
VA Connecticut Health Care System—Newington Campus	Newington, Conn.
White River Junction VA Regional Outpatient Clinic	White River Junction, Vt.
VISN 2	
Samuel S. Stratton VA Medical Center	Albany, N.Y.
VA Western New York Health Care System—Buffalo	Buffalo, N.Y.
Canandaigua VA Medical Center	Canandaigua, N.Y.
VA Health Care Network Upstate New York at Syracuse	Syracuse, N.Y.
VISN 3	
Bronx VA Medical Center	Bronx, N.Y.
Brooklyn VA Medical Center	Brooklyn, N.Y.
VA Hudson Valley Castle Point VA Medical Center	Castle Point, N.Y.
Northport VA Medical Center	Northport, N.Y.
VISN 4	
James E. Van Zandt VA Medical Center	Altoona, Pa.
Coatesville VA Medical Center	Coatesville, Pa.
Lebanon VA Medical Center	Lebanon, Pa.
Philadelphia VA Medical Center	Philadelphia, Pa.
VA Pittsburgh Healthcare System—Highland Drive Campus	Pittsburgh, Pa.
Wilkes-Barre VA Medical Center	Wilkes-Barre, Pa.
Wilmington VA Medical Regional Outpatient Clinic	Wilmington, Del.
VISN 5	
Baltimore VA Medical Center	Baltimore, Md.

Continued

Facility	City and state
Louis A. Johnson VA Medical Center	Clarksburg, W.Va.
Beckley VA Medical Center	Beckley, W.Va.
Hampton VA Medical Center	Hampton, Va.
Hunter Holmes McGuire VA Medical Center	Richmond, Va.
VISN 6	
Salem VA Medical Center	Salem, Va.
Asheville VA Medical Center	Asheville, N.C.
Durham VA Medical Center	Durham, N.C.
Fayetteville VA Medical Center	Fayetteville, N.C.
Salisbury VA Medical Center	Salisbury, N.C.
VISN 7	
Atlanta VA Medical Center	Atlanta, Ga.
Augusta VA Medical Center	Augusta, Ga.
Birmingham VA Medical Center	Birmingham, Ga.
Tuscaloosa VA Medical Center	Tuscaloosa, Ala.
Ralph H. Johnson VA Medical Center	Charleston, S.C.
William Jennings Bryan Dorn VA Medical Center	Columbia, S.C.
VISN 8	
Bay Pines VA Medical Center	Bay Pines, Fla.
North Florida/South Georgia Veterans Health System	Gainesville, Fla.
James A. Haley Veterans Hospital	Tampa, Fla.
West Palm Beach VA Medical Center	West Palm Beach, Fla.
San Juan VA Medical Center	San Juan, P.R.
VISN 9	
Huntington VA Medical Center	Huntington, W.Va.
Louisville VA Medical Center	Louisville, Ky.
Lexington VA Medical Center	Lexington, Ky.
Memphis VA Medical Center	Memphis, Tenn.
James H. Quillen VA Medical Center	Mountain Home, Tenn.
Alvin C. York VA Medical Center	Murfreesboro, Tenn.
Nashville VA Medical Center	Nashville, Tenn.
VISN 10	
Cincinnati VA Medical Center	Cincinnati, Ohio
VA Healthcare System of Ohio	Cleveland, Ohio
VA Outpatient Clinic	Columbus, Ohio
Dayton VA Medical Center	Dayton, Ohio

Continued from Previous Page

Facility	City and state
VISN 11	
Ann Arbor VA Medical Center	Ann Arbor, Mich.
Battle Creek VA Medical Center	Battle Creek, Mich.
Aleda E. Lutz VA Medical Center	Saginaw, Mich.
Richard L. Roudebush VA Medical Center	Indianapolis, Ind.
VISN 12	
North Chicago VA Medical Center	North Chicago, Ill.
Marion VA Medical Center	Marion, Ill.
William S. Middleton Memorial Veterans Hospital	Madison, Wis.
Tomah VA Medical Center	Tomah, Wis.
Clement J. Zablocki VA Medical Center	Milwaukee, Wis.
VISN 13	
Fargo VA Medical Regional Outpatient Clinic	Fargo, N.Dak.
VA Black Hills Healthcare System—Fort Meade	Fort Meade, S.Dak.
VA Black Hills Healthcare System—Hot Springs	Hot Springs, S.Dak.
Royal C. Johnson VA Medical Regional Outpatient Clinic	Sioux Falls, S.Dak.
Minneapolis VA Medical Center	Minneapolis, Minn.
St. Cloud VA Medical Center	St. Cloud, Minn.
VISN 14	
VA Central Iowa Healthcare System—Des Moines	Des Moines, Iowa
Iowa City VA Medical Center	Iowa City, Iowa
Lincoln VA Medical Center	Lincoln, Nebr.
Omaha VA Medical Center	Omaha, Nebr.
VISN 15	
Harry S. Truman Memorial Veterans' Hospital	Columbia, Mo.
St. Louis VA Medical Center—John Cochran Division	St. Louis, Mo.
Dwight D. Eisenhower VA Medical Center	Leavenworth, Kans.
Wichita VA Medical Regional Outpatient Clinic	Wichita, Kans.
VISN 16	
Biloxi VA Medical Center	Biloxi, Miss.
G. V. (Sonny) Montgomery VA Medical Center	Jackson, Miss.
Alexandria VA Medical Center	Alexandria, La.
New Orleans VA Medical Center	New Orleans, La.
Overton Brooks VA Medical Center	Shreveport, La.
Oklahoma City VA Medical Center	Oklahoma City, Okla.
Little Rock VA Medical Center	Little Rock, Ark.

Continued from Previous Page

Facility	City and state
VISN 17	
Houston VA Medical Center	Houston, Tex.
VA North Texas Health Care System—Sam Rayburn Memorial Veterans Center	Bonham, Tex.
Central Texas Veterans Health Care System—Thomas T. Connally Medical Center	Marlin, Tex.
South Texas Veterans Health Care System—Audie L. Murphy Memorial Veterans Hospital	San Antonio, Tex.
Amarillo VA Medical Center	Amarillo, Tex.
VISN 18	
Carl T. Hayden VA Medical Center	Phoenix, Ariz.
Tucson VA Medical Center	Tucson, Ariz.
VISN 19	
Cheyenne VA Medical Center	Cheyenne, Wyo.
VA Medical Center—Sheridan	Sheridan, Wyo.
Denver VA Medical Center	Denver, Colo.
Salt Lake City VA Medical Center	Salt Lake City, Utah
VISN 20	
Boise VA Medical Center	Boise, Idaho
Portland VA Medical Center	Portland, Oreg.
VA Puget Sound Healthcare System—Seattle	Seattle, Wash.
Spokane VA Medical Center	Spokane, Wash.
VISN 21	
VA Central California Health Care System	Fresno, Calif.
VA Palo Alto Health Care System	Palo Alto, Calif.
San Francisco VA Medical Center	San Francisco, Calif.
Ioannis A. Lougaris VA Medical Center	Reno, Nev.
VISN 22	
Jerry L. Pettis Memorial VA Medical Center	Loma Linda, Calif.
Long Beach VA Medical Center	Long Beach, Calif.
VA Greater Los Angeles Healthcare System—Wadsworth Division (West Los Angeles VA Medical Center)	Los Angeles, Calif.
VA Greater Los Angeles Healthcare System—Southern California System of Clinics	Sepulveda, Calif.
San Diego VA Medical Center	San Diego, Calif.

Continued from Previous Page

Note: The eight VA facilities that are partners in joint ventures are not listed.

Table 7: DOD Facilities With Active Sharing Agreements and Their Locations

Facility	City and state
Army	
Keller Army Community Hospital, West Point	West Point, N.Y.
Tobyhanna Army Depot	Tobyhanna, Pa.
Walter Reed Army Institute of Research	Washington, D.C.
Walter Reed Army Medical Center	Washington, D.C.
Medical Research Materiel Command, Fort Detrick	Frederick, Md.
U.S. University of Health Sciences	Bethesda, Md.
DeWitt Army Community Hospital, Fort Belvoir	Fort Belvoir, Va.
Womack Army Medical Center, Fort Bragg	Fayetteville, N.C.
Moncrief Army Hospital, Fort Jackson	Columbia, S.C.
Dwight David Eisenhower Army Medical Center, Fort Gordon	Augusta, Ga.
Bayne-Jones Army Community Hospital, Fort Polk	Leesville, La.
Irwin Army Community Hospital, Fort Riley	Manhattan, Kans.
Darnell Army Community Hospital, Fort Hood	Killeen, Tex.
Brooke Army Medical Center, Fort Sam Houston	San Antonio, Tex.
4005th Army Augmentation Reserve Unit	Houston, Tex.
Raymond W. Bliss Army Community Hospital, Fort Huachuca	Sierra Vista, Ariz.
Madigan Army Medical Center, Fort Lewis	Tacoma, Wash.
Bassett Army Community Hospital, Fort Wainwright	Fairbanks, Alaska
Air Force	
107th Medical Squadron, New York Air National Guard	Niagara Falls, N.Y.
74th Medical Group, Wright-Patterson AFB	Dayton, Ohio
375th Medical Group, Scott AFB	Scott AFB, Ill.
Arnold Air Force Station	Tullahoma, Tenn.
2nd Medical Group, Barksdale AFB	Shreveport, La.
81st Medical Group, Keesler AFB	Biloxi, Miss.
59th Medical Wing, Lackland AFB	San Antonio, Tex.
319th Medical Group, Grand Forks AFB	Grand Forks, N.Dak.
Minot AFB, 5th Medical Group	Minot, N.Dak.
355th Medical Group, Davis—Monthan AFB	Tucson, Ariz.
77th Medical Group, Mather AFB	Mather AFB, Calif.
157th Medical Squadron, Air Mobility Command, Army National Guard	Peese, N.H.
92nd Medical Group, Fairchild AFB	Spokane, Wash.

Continued

Facility	City and state
Coast Guard	
U.S. Coast Guard Academy	New London, Conn.
Navy	
Naval Hospital	Portsmouth, Va.
Naval Hospital	Pensacola, Fla.
Navy Reserve (Fleet Hospital Cheyenne)	Cheyenne, Wyo.
Navy Reserve	Spokane, Wash.
Naval Hospital Guam	Guam

Continued from Previous Page

Other Medical Services Provided

The results of our survey show that VA provided 21 categories of other medical services under 49 active agreements and DOD provided 18 categories of other medical services under 17 active agreements. VA reported receiving more than $4 million from DOD for these other services (see table 8). Of this amount, $898,719 was reported for dental services, ranging from $37 to $521,119 per agreement, excluding bartered agreements. Another $183,702 was reported for pharmacy services provided to DOD beneficiaries, ranging from $60 to $180,162 per agreement. DOD reported receiving almost $900,000 from VA for these other medical services; more than a third ($355,790) was for filling prescriptions for VA beneficiaries (see table 9). Support services provided by VA and DOD in fiscal year 1998 and the reimbursements collected are shown in table 10.

Table 8: Other Medical Services Provided by VA

VA-provided medical service	Amount received
Dental	$898,719
Prosthetic devices/implants	328,696
Women's clinic	194,143
Pharmacy	183,702
Physical therapy	83,300
Psychologist supervision	73,177
Physical examinations/preventive care	56,010
Ears	39,360
Nuclear medicine	12,378
Bone scans	6,949
Depleted uranium outpatient services[a]	6,000
PET (positron-emission tomography) scans	5,800
Echocardiogram interpretations	4,020
Dietician	3,517
Mental health	3,312
Laboratory services	2,061
Eyeglasses	68
Health and medical technicians	[b]
Nursing supervision	[b]
Nursing	[b]

Continued

VA-provided medical service	Amount received
Miscellaneous other medical services[c]	2,245,297
Total	**$4,146,509**

Continued from Previous Page

[a]Services to treat patients who have had contact with or have been contaminated by depleted uranium—a low-level radiation hazard that results when the waste products of uranium processing are used in weapons, such as shell casings.

[b]Facility could either not break out amount received for individual service or service was bartered.

[c]Includes other services for five VA hospitals that were unable to break out costs by specific services.

Table 9: Other Medical Services Provided by DOD

DOD-provided medical service	Amount received
Pharmacy	$355,790
Hyperbarics[a]	153,340
General surgeon support	75,194
Nuclear medicine	44,585
Blood	42,800
Obstetrician/gynecology	33,402
Preventive care	27,619
Sleep studies	12,100
Laboratory	5,683
Physician assistant	5,265
Nursing supervision	3,173
Ambulatory surgical unit	2,124
Dietician	840
Dental	[b]
Health and medical technicians	[b]
Orthopedic surgery	[b]
PET scans	[b]
Miscellaneous other medical services	134,570
Total	**$896,485**

[a]Hyperbarics is the administration of oxygen under increased pressure while the patient is in an airtight chamber. These treatment facilities—which have been used to treat carbon monoxide poisoning, gas gangrene, burns, smoke inhalation, and decompression sickness (bends)—are expensive to build and operate and are needed by only a small number of patients.

[b]Facility could either not break out amount received for individual service or service was bartered.

Table 10: Support Services Provided by VA and DOD and Reimbursements Collected in Fiscal Year 1998

	VA		DOD	
Support service	**Number of agreements**	**Amount collected[a]**	**Number of agreements**	**Amount collected[a]**
Laundry	23	$2,063,848	3	$347,219
Research	2	161,475	5	138,661
Administration and management	4	65,071	4	0
Education and training	55	8,496	3	0
Other[b]	22	421,656	6	376,116
Total	**105[c]**	**$2,720,546**	**18[c]**	**$861,996**

[a]Not all survey respondents provided reimbursements collected.

[b]Includes services such as housekeeping, waste collection, police and fire protection, and pest control.

[c]Agreements can contain more than one service; therefore, columns do not add to total.

Comments From the Department of Veterans Affairs

DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON DC 20420

APR 1 1 2000

Mr. Stephen P. Backhus
Director, Veterans' Affairs and Military
Health Care Issues
Health Education and Human Services Division
U. S. General Accounting Office
441 G Street, NW
Washington, DC 20548

Dear Mr. Backhus,

We have reviewed your draft report, ***VA AND DEFENSE HEALTH CARE: VA and DOD Need to Reevaluate Policies Affecting the Resource Sharing Program*** (GAO/HEHS-00-52) and its recommendations. While we agree with GAO that there are numerous opportunities for improvement in the technical administration of our joint resource sharing program, we believe that the reviewers could have highlighted better a fundamental barrier to Department of Veterans Affairs/Department of Defense (VA/DOD) sharing activity.

On February 9, 1999, the TRICARE Assistant General Counsel posted an e-mail memorandum stating that "Medical Treatment Facilities (MTFs) must normally refer their prime enrollees to network (TRICARE) providers for any care that is not available in the direct care (military) system." This effectively prohibits VA-DOD sharing agreements because the agreements constitute a network "competing" with TRICARE. Instead, VA facilities would only treat DOD beneficiaries as part of the TRICARE provider networks. DOD has given this memorandum wide distribution throughout the military health system and TRICARE. Because of this legal opinion, MTFs are reluctant to use or renew existing sharing agreements, much less enter into new ones.

VA is committed to working closely with DOD to assure the ongoing success of this cooperative venture. Although GAO's objective was to assess the current status of the program, we believe that the draft report fails to adequately address existing issues that impact progress in resolving future sharing activities between the Departments. No VA policies have created any barriers to sharing with DOD.

GAO focuses on program administration, and, in particular, on management of the VA-DOD database. This database, twice redesigned at VHA expense (most recently in 1998), is VA's administrative responsibility, although we must obviously rely on coordinated input from DOD. GAO states that in the

2. Mr. Stephen P. Backhus

absence of accurate and comprehensive data from the database, it is not possible to "assess the overall effectiveness of the sharing program." It should be emphasized that the database was never designed to be used as a broad evaluative tool. It was created to develop data for the Report to Congress required by 38 U.S.C. 8111. In evaluating program effectiveness, particularly in relation to fiscal reimbursement, we also use other data generated within VHA. GAO recommends that VHA's Medical Sharing Office measure the actual exchange of services between VA and DOD sharing partners and under the joint venture sharing agreements. As a stand-alone effort, this would be a massive undertaking, the cost of which would far outweigh any discernible benefits. Design of a system that consistently measures health care workload is an intensive Department-wide undertaking that VHA is addressing on an ongoing basis. Sharing agreement services, counted as non-veteran workload, will be only one component of the systemwide effort. In order for this to be valid, our system must also be compatible with DOD data information systems. Until such time as these systemwide efforts to validate clinical workload are implemented, meaningful workload analyses necessarily will be limited.

In summary, it is VHA's position that GAO's report seriously downplays DOD's resistance to cooperative federal sharing opportunities, despite agreement by many participants that sharing agreements are extremely beneficial. An impartial reader of the report would have minimal guidance in identifying the single obvious roadblock to future sharing success. VA has made significant progress in removing barriers to comprehensive sharing. We have expedited administrative processes and reduced our agreement approval turnaround time to three working days. Our reimbursement policies are based on incremental costs and are clearly delineated in published handbooks. VA medical facilities are clearly authorized to retain earnings from sharing agreements. VHA has consistently taken every possible step to be a cooperative partner in our sharing activities with DOD. Regrettably, that cooperative spirit has not been reflected in DOD policy. Nevertheless, VHA is committed to continued cooperation with DOD to set the program on track.

The enclosure details our comments to the draft report's recommendations. It also contains additional comments for your consideration. We appreciate the opportunity to comment on your draft report.

Sincerely,

Dennis Duffy
Assistant Secretary for
Planning and Analysis

Enclosure

Enclosure

DEPARTMENT OF VETERANS AFFAIRS COMMENTS
TO GAO DRAFT REPORT,
VA AND DEFENSE HEALTH CARE: VA and DOD Need to Reevaluate Policies Affecting the Resource Sharing Program
(GAO/HEHS-00-52)

GAO recommends that the Secretaries of Defense and Veterans Affairs should assess how best to achieve the goals of health resource sharing considering the changes that have occurred over the last decade in the VA and DOD health care systems and the population they serve. As part of this assessment, current barriers to sharing should be considered. For example, the Secretaries should determine what changes, if any, are needed in methods for setting reimbursement rates and facility budgets to assist in meeting these goals. In addition, the Secretary of DOD should reassess the recent policy prohibiting the sharing of direct medical care and, if appropriate, modify TRICARE contract language to allow VAMCs to share health resources as they did before the policy was announced.

Do Not Concur - GAO's draft report seriously downplays DOD's resistance to cooperative federal sharing activity. This recommendation should apply specifically to the Secretary of the Department of Defense. VA has taken strong actions to remove virtually all barriers to comprehensive sharing. We will continue to seek ways to work cooperatively with DOD and to actively participate with other program officials in reassessing and implementing improved program goals.

GAO also recommends that to increase usefulness of VA and DOD's joint database for assessing sharing and annual reports to the Congress that use information from the database, the Secretary should direct the VA Medical Sharing Office to:

- **measure the actual exchange of services between VA and DOD sharing partners and under the joint venture sharing agreements between VA and DOD facilities,**

Do not concur - Even with significantly expanded resource support, collection and aggregation of such data by the Medical Sharing Office as a stand-alone effort would be a massive undertaking. Even more important is the fact that the cost of such a venture would far outweigh any anticipated benefits for improved program implementation that these data might provide.

It is noted, however, that at a systemwide level, VA is designing a system to consistently measure health care workload at all operational levels. Medical

Enclosure

DEPARTMENT OF VETERANS AFFAIRS COMMENTS
TO GAO DRAFT REPORT,
VA AND DEFENSE HEALTH CARE: VA and DOD Need to Reevaluate Policies Affecting the Resource Sharing Program
(GAO/HEHS-00-52)
Continued

sharing activity, including both ambulatory care and inpatient services, will be recorded as part of this systemwide effort. For such efforts to be valid with regard to VA/DOD sharing, however, it will first be necessary to assure that data information systems the two agencies use are compatible. A firm timetable for full implementation of the workload information system has not yet been established.

- **include more in-depth information on national initiatives undertaken by the VA/DOD Executive Council, and**

Concur with qualification - The Medical Sharing Office, in conjunction with (and with the agreement of) its DOD counterparts, will work with respective top management participants in the VA/DOD Executive Council to facilitate the sharing of key information about national initiatives that the Executive Council addresses. It will ultimately be the determination of Council members as to which information is appropriate for inclusion in the Report to Congress.

- **include information on sharing activities authorized outside of the Sharing Act.**

Concur with qualification - The Annual VA-DOD Report to Congress on Healthcare Resources Sharing already includes a significant number of activities that are outside the statutory authority of the VA-DOD Sharing Law. In fact, at least half of the information included in recent VA-DOD Reports to Congress involves projects that are not encompassed by the Law. However, VHA's Medical Sharing and Purchasing Office, with assistance from DOD's Office of Health Affairs, will endeavor to assure that future reports reflect a description of all relevant sharing activities.

Additional Comments:

We offer the following additional comments on aspects of administration GAO identified as problem areas (GAO statements are underlined):

- Only 72 percent of the 572 agreements listed as active were active. At any given time during the year agreements expire and are not renewed.

Enclosure

DEPARTMENT OF VETERANS AFFAIRS COMMENTS
TO GAO DRAFT REPORT,
VA AND DEFENSE HEALTH CARE: VA and DOD Need to Reevaluate Policies Affecting the Resource Sharing Program
(GAO/HEHS-00-52)
Continued

VHA has insufficient staff to monitor these agreements except once a year (August) for the annual Report to Congress. Also, there is a definitional problem – if the station does not inform us that the agreement is not being used (or may be used in the future) we consider it to be "active" unless told otherwise.

- Thirty one percent of VA survey respondents cited the approving process as a barrier. For several years we have approved all agreements within 36 working hours. It would be helpful to know what "barriers" were being cited. Approval from VHA Headquarters is required so the agreements can be counted in the database. The approval process also serves as a way to provide general program oversight.
- VAMCs generally charge the full cost of providing care to DoD beneficiaries, including overhead costs such as administration, whereas DoD bills at less than full cost for VA beneficiaries. We believe the reverse is true. Some MTFs have attempted to bill us at full MEPRS cost. Our guidance (VHA Handbook 1660.1 "VA-DoD Health Resources Sharing" stresses incremental costs.
- "In the absence of this information (accurate and complete data), as well as data on the associated costs and benefits of sharing, it is not possible to assess the overall effectiveness of the sharing program." (Last sentence in "Conclusions"). The purpose of the database was to develop data for the Report to Congress, not to be used as an evaluative tool. The limits of the database for use as an evaluative tool should have been obvious from the initial review.

- VHA initiated a Subsistence Prime Vendor Program in August 1996 and later expanded the program to allow Other Government Agencies (OGA) to have access to the prime vendor contract for purchasing food products and supplies. Approximately 42 DOD entities are currently using the VHA contract. This amounts to 42 agreements, generating $10,328,601.

- VA and DOD have approximately 230 sharing agreements that involve dentistry. Numerous VA facilities provide dental exams, dental x-rays and dental treatment procedures to support active duty, reservist, and Guard members when possible. In addition, there are agreements that involve sharing of dental staff and equipment resources to support dental education, to provide dental implants services, to offer dental sterilization support, and numerous other activities.

3

Enclosure

DEPARTMENT OF VETERANS AFFAIRS COMMENTS
TO GAO DRAFT REPORT,
VA AND DEFENSE HEALTH CARE: VA and DOD Need to Reevaluate Policies Affecting the Resource Sharing Program
(GAO/HEHS-00-52)
Continued

- There is no mention in the report of resource sharing between the two agencies in relation to telemedicine. Both agencies have considerable resources invested in telemedicine development. In much the same way as the development of the general Internet, there is a need for standards to be set to insure there is a solid foundation for telemedicine in the future.

Comments From the Department of Defense

THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D. C. 20301-1200

HEALTH AFFAIRS

MAY 1 2000

Mr. Stephen P. Backhus
Director, Veterans' Affairs and Military Health Care Issues
Health Education and Human Services Division
U.S. General Accounting Office
441 G Street, Northwest
Washington, DC 20548

Dear Mr. Backhus:

This is the Department of Defense (DoD) response to the General Accounting Office (GAO) draft report, "VA AND DEFENSE HEALTH CARE: VA and DoD Need to Reevaluate Policies Affecting the Resource Sharing Program", March 17, 2000 (GAO Code 101623/OSD CASE 1971).

The Department appreciates your review of the DoD/VA sharing program and welcomes your recommendations to improve it. The Department of Defense will continue to pursue new opportunities to further the Department of Veterans Affairs (VA)/DoD Health Care Resources Sharing Program, while also finding improved ways to manage TRICARE. Our responses to your recommendations are enclosed. We do suggest clarifying your intent on page 26, where you appear to dispute our reported number of 137 VA facilities that have agreements as TRICARE network providers. Our number is verifiable and its source is a VA periodic report provided to us. You probably intended to portray the number of VA facilities actually seeing DoD beneficiaries as of a particular point in time.

Sincerely,

Dr. Sue Bailey

Enclosure:
As stated

GAO DRAFT REPORT DATED MARCH 17, 2000
(GAO CODE 101623) OSD CASE 1971

"VA AND DEFENSE HEALTH CARE: VA AND DOD NEED TO REEVALUATE POLICIES AFFECTING THE RESOURCE SHARING PROGRAM"

DEPARTMENT OF DEFENSE COMMENTS
TO THE GAO RECOMMENDATION

* * * * *

RECOMMENDATION 1: The GAO recommended that the Secretary of Defense assess how best to achieve the goals of health resource sharing considering the changes that have occurred over the last decade in the VA and DoD health care systems and the populations they serve. As part of this assessment, current barriers to sharing should be considered. For example, the Secretaries should determine what changes, if any, are needed in methods for setting reimbursement rates and facility budgets in meeting these goals. (p.30/Draft Report)

DOD RESPONSE TO THE DRAFT REPORT. Concur. The Assistant Secretary of Defense (Health Affairs) has initiated the GAO recommendation through its close participation with VA in the VA/DoD Executive Council. A Health Care Sharing Work Group is being created under the Executive Council to facilitate sharing and resolve sharing-related issues. A Financial Committee has also created reimbursement rate guidelines.

RECOMMENDATION 2: In addition, the Secretary of DoD should reassess the recent policy prohibiting the sharing of direct medical care and, if appropriate, modify TRICARE contract language to allow VAMCs to share health resources as they did before the policy was announced.

DOD RESPONSE TO THE DRAFT REPORT. Concur with clarifying the policy. However, there has been no policy that prohibits direct medical care sharing. Medical facilities have been and remain free to refer active duty personnel to VA facilities. That will be reaffirmed in a forthcoming policy memorandum.

GAO Contacts and Staff Acknowledgments

GAO Contacts

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Staff Acknowledgments

In addition to those named above, the following staff made key contributions to this report: Wendy Fleischer, Susan Lawes, Elsie Picyk, Mary Reich, Karen Sloan, Connie Wilson, and Craig Winslow.

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