

**GAO**

**Testimony**

Before the Subcommittee on Health, Committee on  
Veterans Affairs, House of Representatives

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**VA AND DEFENSE  
HEALTH CARE**

**Rethinking of Resource  
Sharing Strategies is  
Needed**

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Veterans' Affairs and Military Health Care Issues  
Health, Education, and Human Services Division



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# VA and Defense Health Care: Rethinking of Resource Sharing Strategies Is Needed

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Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss the Department of Veterans Affairs' (VA) and the Department of Defense's (DOD) sharing of federal health care resources. VA and DOD combined provide health care services to more than 12 million beneficiaries and operate more than 700 medical facilities at a cost of about \$34 billion annually. As you know, in May 1982, the Congress enacted the VA and DOD Health Resources Sharing and Emergency Operations Act (Sharing Act) to promote more cost-effective use of these resources and more efficient delivery of care.<sup>1</sup> Specifically, the act authorizes VA medical centers (VAMC) and military treatment facilities (MTF) to become partners and enter into sharing agreements to buy, sell, and barter medical and support services.

You asked us to conduct a review of the sharing program, which we initiated in January 1999. As part of this review, we visited a number of VA and DOD facilities participating in sharing and surveyed over 400 local sharing partners to determine the extent to which VA and DOD actually exchange services—the first time such data have been collected. Our report, being issued today, provides extensive information on the extent of sharing, the benefits reported by VA and DOD, and the barriers and challenges both agencies face in their efforts to share health resources.<sup>2</sup> My statement today will summarize our findings and highlight the steps we believe VA and DOD need to take in the future to ensure the efficient use of federal health care resources.

In summary, we found that while VA and DOD partners are sharing resources and have reported a number of benefits from this exchange, the majority of sharing is occurring under a few agreements and at a few facilities. In addition, certain barriers have created confusion about the status of current sharing agreements and presented challenges for future collaboration. Finally, both VA and DOD face changes in their health care delivery systems that are likely to alter the potential for sharing. To provide stability to the current sharing program and to have VA and DOD jointly assess the most cost-effective ways to share health care resources in the future, we are making several recommendations.

Our survey and fieldwork identified a number of benefits that have resulted from sharing, including increased revenue, enhanced staff proficiency, fuller utilization of staff and equipment, and reduced costs.

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<sup>1</sup>P.L. 97-174, 96 Stat. 70.

<sup>2</sup>*VA and Defense Health Care: Evolving Health Care Systems Require Rethinking of Resource Sharing Strategies* (GAO/HEHS-00-52, May 17, 2000).

As required by the law, VA and DOD have reported annually to the Congress on the status of the sharing program and have claimed growth. For fiscal year 1998, VA and DOD stated that virtually all VAMCs and MTFs had sharing agreements under which more than 10,000 services could potentially be exchanged. However, these numbers reflect the number of facilities that have an agreement and the range of services that could be exchanged, but they do not capture the actual volume of services exchanged under the agreements.

Our survey revealed that 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 and support services. However, most activity occurred under a few agreements and at a few facilities. Reimbursements for care provided under sharing agreements—another indicator of activity—were similarly concentrated. Three-quarters of the \$29 million in reimbursements for provided care was collected by only 26 of the 146 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.

Our work also identified certain barriers that could jeopardize current sharing agreements and limit future collaboration. In addition to inconsistent reimbursement and budgeting policies—two long-standing barriers that we have reported on previously—a more recent barrier has major implications for the nature and future of sharing. Specifically, a 1999 DOD legal opinion and subsequent policy has caused concern among VA and DOD officials that many of these agreements could, in effect, be nullified. DOD's contracts with private health care companies through its managed care program, TRICARE, may supersede the sharing of direct medical care between VA and DOD facilities. According to the military Surgeons General and local VA and DOD officials, the policy is causing confusion over what services can be shared. Additionally, changes to DOD payment procedures, initiated without clear guidance to VA or DOD contractors, has exacerbated the situation. According to VA officials, local VA partners are being paid too little, too late, or not at all. Over the past 2 weeks, we have been informed that VA and DOD have taken certain steps to begin to address some of the concerns. However, we have not yet been provided the opportunity to review these steps to determine whether they are adequate to resolve these problems.

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## Background

As one of the world's largest health care systems, VA operates 181 VAMCs and 272 outpatient clinics nationwide at a cost of about \$18 billion a year. DOD spends about \$16 billion on health care, most of which is provided at the more than 500 Army, Navy, and Air Force military hospitals and clinics worldwide. In an effort to maximize the use of these resources, VA and DOD are participating in several types of sharing activities.

- Local sharing agreements allow VAMCs and MTFs to exchange inpatient care, outpatient care, and ancillary services as well as support services, such as education and training and laundry.
- Joint venture sharing agreements pool resources to build new facilities or to capitalize on existing facilities. Joint ventures require more cooperation and flexibility than local agreements because VA and DOD must work together to develop multiple sharing agreements and establish operational procedures that allow them to operate as one system.
- National sharing initiatives, under the VA/DOD Executive Council, are interagency initiatives, such as joint disability discharge physicals, which eliminated the duplicative examinations that military personnel were required to undergo to be discharged and receive VA disability benefits.
- Other collaborative efforts not specifically covered under the Sharing Act include the joint purchasing of pharmaceuticals, laboratory services, medical supplies and equipment, and other support services.

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. VA estimates that the number of veterans will drop to 16 million by 2020. DOD's beneficiary population is also changing. The number of military retirees is increasing and, while the number of active duty personnel is declining, the number of dependents is increasing. 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.

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: TRICARE Prime, similar to a health maintenance organization; TRICARE Extra, similar to a preferred provider organization; and TRICARE Standard, a fee-for-service benefit. 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.

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## **VA and DOD Partners Report Benefits From Sharing Resources, but Sharing Activity Is Concentrated**

VA and DOD partners responding to our survey attributed a number of specific benefits to their local sharing agreements. 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 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 of sharing. Since the sharing law was enacted, VA and DOD have claimed growth in the sharing program, citing increases in the number of facilities with sharing agreements and the range of services that could potentially be exchanged under these agreements. Between fiscal years 1984 and 1994, VA and DOD reported that the combined total of VA and DOD facilities with local sharing agreements had increased from 102 to 284.<sup>3</sup> For fiscal year 1998, the most recent year for which the annual report was issued, VA and DOD stated that virtually all VAMCs and MTFs were involved in sharing agreements. VA and DOD also reported that, between fiscal years 1987 and 1998, the number of services covered under these agreements had increased from 1,387 to 10,586 services. In fiscal year 1998, that number included services that could be provided by VA through TRICARE.

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<sup>3</sup>VA and DOD have reported the number of facilities with sharing agreements since 1984; the actual number of agreements has only been reported since fiscal year 1992.

VA and DOD's numbers, however, indicate only the potential for sharing, not the actual volume of services shared. Through our survey, we found that, in fiscal year 1998, about 70 percent of the local sharing agreements were active—that is, services had been provided. VA provided services under 352 agreements at 108 facilities, and DOD provided services under 60 agreements at 37 facilities. About 75 percent of these agreements were for direct medical care provided mostly by VA. VA and DOD partners also reported collecting a total of \$29 million in sharing agreement reimbursements for providing health and support services in fiscal year 1998. Although dollar values were not assigned for all bartered agreements, those that did assign a value reported about \$775,000.

Eighty-four percent of the total reimbursements reported were for direct medical care. VA and DOD also provided other health services, such as pharmacy, dental, and vision, as well as support services, such as training and laundry, under sharing agreements. For other types of health services, VA and DOD collected a total of almost \$5 million; for support services, VA and DOD collected a total of over \$3.5 million, with VA receiving \$2 million for laundry services.

More recently, VA and DOD partners have entered into a total of eight joint ventures. Six of the eight were operational as of 1998, generating a notable amount of activity. For example, in 1998, these six joint ventures reported a total of about 360,000 episodes of care. Finally, VA and DOD have pursued—to a lesser degree—opportunities to share through national initiatives and sharing under authority other than the Sharing Act.

While actual sharing is occurring through a majority of agreements, most of this activity is under just a few local agreements and at a few facilities, usually in locations where VA and DOD facilities were nearby or where facilities provided specialized services. For example, 75 percent of all inpatient care provided occurred under just 12 local sharing agreements. Similarly, 26—or 18 percent—of the facilities participating in active agreements collected three-quarters of the \$29 million in reimbursements.

Activity was similarly concentrated at the joint venture sites in Nevada and New Mexico—the two locations where VA and DOD integrated many hospital services and administrative processes. Specifically, 83 percent of all episodes of care provided through the operational joint ventures were provided at these two locations. In addition, 13 VAMCs and 22 MTFs reported that, in fiscal year 1998, they had entered into one or more joint purchasing contracts—not covered by the Sharing Act—to purchase pharmaceuticals, laboratory services and supplies, medical supplies and equipment, and other types of services.

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## **Several Barriers and Challenges Require VA and DOD to Rethink Resource Sharing Strategies**

Local VA and DOD officials identified a number of long-standing and new barriers that could jeopardize current sharing agreements or impede further sharing of federal health care resources. Of particular concern are the implications that a 1999 TRICARE policy and program changes have had for sharing. Unless these barriers and challenges are overcome, VA and DOD will face difficulties sharing resources in the future.

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### **Long-Standing Barriers Continue to Jeopardize Sharing**

Among the barriers survey respondents identified, several are long-standing—policies governing reimbursement and budget and processes for approving sharing agreements. Regarding reimbursement policies, we found that some VA and DOD hospitals set reimbursement rates at total costs rather than at incremental costs. VA has developed guidance that supports 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. In addition, MTFs would have more incentive to share if they kept their own reimbursements for services provided under sharing agreements, as VAMCs do. However, local DOD officials told us that some MTFs still deposit funds received from sharing agreements into a centrally managed DOD account, although DOD guidance states that MTFs can keep these funds. MTF officials may be misinterpreting DOD's guidelines on the authority to retain reimbursements from VA partners. In our survey, a number of respondents specifically noted that clarification of reimbursement guidelines would provide a greater incentive to share.

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 indicated that such experiences have discouraged them from seeking other potential sharing arrangements.

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## TRICARE Policies Call Into Question Current and Future Sharing

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 constitute competing networks with TRICARE contractors, DOD issued a policy memorandum in May 1999. This policy has caused concern among VA and DOD officials that many of these agreements could, in effect, be nullified. 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. The legal opinion further states that referring a beneficiary to a VAMC sharing partner violates the TRICARE contract unless the VAMC is a member of the network. While the policy still allowed sharing for support services, it called into question the local sharing agreements in which VA provided direct medical care, which accounted for about 80 percent of the services covered under the agreements that were reported to us as active.

DOD also issued a policy transferring funding and payment responsibility for MTF-referred care—primarily for active duty members—from the MTFs to TRICARE support contractors, effective October 1, 1999. VA officials told us that since 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 and the lack of clear guidance from DOD. 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 not getting reimbursed for a number of the services it provided. According to VA officials, this policy has negatively affected collaboration and, unless addressed, will continue to be a disincentive to future efforts. We recently learned that VA and DOD have taken certain steps to begin to address some of these concerns, but we have not yet been provided the opportunity to review these steps to determine whether they are adequate remedies.

While TRICARE contractors are encouraged to include VA health care facilities in their networks, VA officials believe that VAMCs will not be used as extensively as they were under the sharing agreements because they will be among many other network providers from which beneficiaries can choose. As of September 1999, DOD reported that 137 VAMCs were TRICARE subcontractors. We recently verified this information.

Due to the expressed concern from VA officials that the TRICARE policy may reduce sharing activity, we conducted a follow-up survey with VA partners to measure the extent to which activity has been affected. We learned that since TRICARE changes went into effect, 82 percent of VA respondents reported that none of their local sharing agreements with DOD have been terminated and a majority reported that the volume of sharing activity had either stayed the same or increased. Of those who reported that agreements had been terminated, more than two-thirds said that the VA facility will continue to provide services to DOD beneficiaries under TRICARE. However, significant problems with reimbursements persist. In particular, local VA partners continue to report that they have not been adequately paid for services rendered.

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## 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 there is excess capacity and cost advantages, 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, 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.

Notwithstanding the recent steps reportedly taken to address certain barriers, VA and DOD will need to consider the criteria and conditions that make resource sharing a cost-effective option for the federal government—not for VA or DOD alone. To determine the most cost-effective means of providing care to beneficiaries from the federal government's perspective, we have recommended that the Secretaries of VA and DOD 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 now serve. In addition, we recommended 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. To provide stability to the current sharing

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program while VA and DOD reassess how best to achieve the goals of resource sharing legislation, we also recommended that the Secretary of Defense direct the Assistant Secretary (Health Affairs) to review and clarify DOD's policy on the extent to which direct medical sharing is permitted with VA.

In commenting on a draft of our report, VA and DOD generally agreed that there are opportunities to improve the administration of the sharing program. VA did not concur with our joint recommendation because it believes it has taken strong actions to improve efforts to reach program goals. While DOD concurred with the joint recommendation and agreed to reassess its policies' effects on the sharing program, it noted that the policy on TRICARE does not prohibit sharing, which seems to contradict its legal opinion on TRICARE. 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. In the event that the two agencies are unable to resolve their differences in a reasonable amount of time, we suggested that the Congress consider providing direction and guidance to clarify the criteria, conditions, roles, and expectations for VA and DOD collaboration.

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Mr. Chairman, this concludes my prepared statement. I will be happy to respond to any questions you or other Members of the Subcommittee may have.

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