United States General Accounting Office

GAO

Report to the Chairman, Subcommittee on Military Personnel and Compensation, Committee on Armed Services, House of Representatives

March 1988

VA/DOD HEALTH CARE

Further Opportunities to Increase the Sharing of Medical Resources

GAO/HRD-88-51

GAO
United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-226429

March 1, 1988

The Honorable Beverly B. Byron
Chairman, Subcommittee on
Military Personnel and Compensation
Committee on Armed Services
House of Representatives

Dear Madam Chairman:

This report responds to your March 13, 1986, request that we determine how well the Veterans Administration and Department of Defense Health Resources Sharing and Emergency Operations Act (Public Law 97-174) has been implemented.

Since the legislation was enacted in May 1982, the Veterans Administration and the Department of Defense have made significant progress in developing sharing agreements, although obstacles remain that impede optimum sharing of medical resources. We are making two recommendations to the Congress for legislative changes that would improve the agencies' ability to share their medical resources and services on a referral basis. We are also making recommendations to the Secretary of Defense and the Administrator of Veterans Affairs directed at eliminating other sharing obstacles we have identified.

As arranged with your office, we are sending copies of the report to the Chairmen of the House and Senate Committees on Appropriations, House and Senate Committees on Veterans' Affairs, and Senate Committee on Armed Services; the Director, Office of Management and Budget; the Secretary of Defense; the Secretaries of the Army, Navy, and Air Force; the Administrator of Veterans Affairs; and other interested parties. We will also make copies available to others upon request.

Sincerely yours,

Lawrence H. Thompson

Lawrence H. Thompson
Assistant Comptroller General

Executive Summary

Purpose

In 1982, the Congress enacted the Veterans Administration and Department of Defense Health Resources Sharing and Emergency Operations Act (Public Law 97-174). A principal objective of this legislation is to promote greater sharing of health care resources between the Veterans Administration (VA) and the Department of Defense (DOD).

The Chairman, Subcommittee on Military Personnel and Compensation, House Committee on Armed Services, asked GAO to determine

- what progress VA and DOD have made in implementing the law,
- whether opportunities for sharing health care resources between the two agencies have been maximized,
- whether current incentives to encourage sharing are adequate,
- whether any obstacles interfere with sharing arrangements, and
- whether any administrative or legislative changes are needed to further encourage sharing.

Background

VA and DOD each provide health care directly to eligible beneficiaries through separate systems of hospitals and clinics. In fiscal year 1987, these systems had budgets of nearly $20 billion. VA and DOD operate more than 300 hospitals and 600 outpatient clinics in the 50 states. Both systems also pay civilian sources to provide medical care to their beneficiaries at combined annual payments in excess of $2 billion. Most of these payments are made by DOD's Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). (See p. 8.)

Public Law 97-174 encourages VA and DOD to share health care resources. The act's legislative history recognizes the importance of having sharing agreements negotiated by federal hospital managers, who have more complete knowledge of local conditions. The act stipulates that sharing agreements negotiated by VA and DOD hospital managers automatically go into effect unless specifically disapproved by higher headquarters officials. (See p. 9.)

Results in Brief

VA and DOD have made significant progress in sharing their health care resources. As of September 1986, the agencies had entered into about 240 sharing agreements. Although the agencies have not estimated the reduction in federal health care costs associated with these agreements, data GAO obtained from local VA and DOD medical facility officials showed that federal health care costs have been and are expected to continue to be reduced as a result of these agreements. Also, local federal hospital

officials cited better patient access to care as a major benefit of locally negotiated sharing agreements. In addition, VA and the Air Force have developed two agreements involving the joint use of federal hospitals that could serve as models for other planned federal facilities.

Although progress has been made, the following obstacles still impede optimum sharing of medical resources:

- The lack of understanding among local VA and DOD hospital officials that reimbursement rates can be set at less than total costs to encourage medical resource sharing.
- The DOD budgetary procedures for treating reimbursements received by DOD from VA under sharing agreements reduce the incentive to share that the law intended to give local hospital administrators.
- The Public Law 97-174 provision that restricts treatment of DOD dependents in VA facilities.
- The restriction on using CHAMPUS funds to reimburse VA facilities for medical care furnished to DOD beneficiaries.

Both legislative and administrative changes are needed to remove these obstacles.

Principal Findings

Problems With Reimbursement Rates

Reimbursement rates proposed by some VA medical centers included all direct and indirect costs associated with the provision of shared medical services and were higher than prices offered by private suppliers. As a result, certain military hospitals had no incentive to share underused VA services. However, sharing guidelines allow hospitals to establish reimbursement rates below those necessary to recoup total costs. The flexibility permitted in establishing reimbursement rates is not understood by many local VA and DOD hospital officials who negotiate the sharing agreements. (See p. 17.)

DOD Reimbursement Procedures Do Not Provide Sharing Incentives as the Law Intended

Public Law 97-174 requires that local medical facilities be reimbursed for services that they provide under VA/DOD sharing agreements. The congressional intent in establishing this reimbursement requirement was to create a financial incentive for those VA and DOD medical facilities having excess capacity to share their medical resources.

VA and DOD differ in their budget treatment of reimbursements. Each VA medical center is credited with any DOD reimbursements received and is allowed to add the amounts reimbursed to the allotment it received for its VA workload. Thus, VA hospital administrators perceive that sharing reimbursements provide them with additional resources. In contrast, although DOD maintains that the projected workload from VA sharing agreements is one factor considered in allocating resources among facilities, it makes no attempt to account for reimbursements separately at the facility level. As a result, there is no guarantee that an individual facility's allocation was increased by the amount of VA reimbursements generated. DOD hospital administrators GAO contacted did not believe that those DOD hospitals that receive reimbursements from VA were allocated additional resources in the DOD budget process. Consequently, some military hospitals have been discouraged from entering into sharing agreements with VA. (See p. 26.)

Restriction on VA Treating DOD Dependents Unnecessary

Public Law 97-174 does not allow VA to treat certain DOD beneficiaries—dependents of active duty and retired members of the uniformed services—under VA/DOD sharing agreements. VA had previously supported this restriction but has recently proposed that the administration support legislative action to allow DOD dependents to be treated under sharing agreements on a space-available, referral basis. The Office of Management and Budget (OMB) has not agreed with this proposal. (See p. 35.)

CHAMPUS Fund Restrictions Discourage Sharing

Congressional and DOD restrictions on using CHAMPUS funds have limited DOD facilities' use of nearby VA medical centers. Many military hospitals cannot refer DOD beneficiaries to VA because those hospitals cannot use CHAMPUS funds and have limited in-house funds to pay VA. These restrictions may prevent the potential benefits associated with treatment of DOD dependents in VA medical centers from being fully realized. (See p. 42.)

Recommendations

GAO recommends that the Congress

- amend Public Law 97-174 to remove the restriction on VA providing health care to DOD beneficiaries under VA/DOD sharing agreements on a referral basis when care of VA's primary beneficiaries would not be adversely affected and

- amend the National Defense Authorization Act of 1987 to specifically authorize the armed services to use CHAMPUS funds to purchase care from VA medical centers.

GAO is also recommending that the Secretary of Defense and the Administrator of Veterans Affairs clear up the confusion about reimbursement rate setting and that the Secretary of Defense revise DOD's reimbursement mechanism to give military hospitals an incentive to share as the Congress intended.

Agency Comments

DOD agreed with GAO's recommendations that the Congress amend legislation to (1) permit VA to treat DOD dependents and (2) authorize CHAMPUS funds to be used to purchase care from VA medical centers. DOD and VA agreed with GAO's recommendation to clear up the confusion about reimbursement rate setting. DOD disagreed with GAO's recommendation to revise DOD's reimbursement mechanism and contended that such a revision would not be consistent with federal budgetary concepts. OMB disagreed with all of GAO's recommendations. OMB contended that allowing VA to treat DOD dependents would increase VA costs and that other sources of care, including care furnished by the private sector through CHAMPUS, are preferable.

Based on information provided to GAO by DOD financial and budget officials, GAO revised its original recommendation and now recommends that local DOD hospital managers be informed explicitly of the amounts of resources being provided in facilities' budgets to handle anticipated reimbursable work under Public Law 97-174 sharing agreements. GAO believes that OMB's position ignores the fundamental objective of the sharing legislation—delivering medical care to eligible beneficiaries in the most cost-effective manner. OMB's position is that sharing of medical resources is not appropriate since the activity could increase costs for the providing agency. GAO disagrees with OMB's position for two reasons. First, no significant cost increase is likely to occur since, in most cases, excess capacity would be shared. Second, OMB's position does not consider the potential for overall savings to the government as a result of sharing between VA and DOD.

GAO's evaluation of the agencies' comments is on pages 23, 33, 40, and 46.

Contents

Abbreviations

CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CT	computerized tomography
DOD	Department of Defense
DM&S	Department of Medicine & Surgery
GAO	General Accounting Office
OMB	Office of Management and Budget
O&M	Operations and Maintenance
USAF	U.S. Air Force
VA	Veterans Administration

Introduction

In 1982 the Congress enacted Public Law 97-174 (38 U.S.C. 5011), the Veterans Administration and Department of Defense Health Resources Sharing and Emergency Operations Act. A principal objective of this legislation is to promote greater sharing of health care resources between the Veterans Administration (VA) and the Department of Defense (DOD), which operate the two largest federal direct health care delivery systems. The act is intended to remove sharing obstacles and give medical facilities incentives to share.

In March 1986, the Chairman, Subcommittee on Military Personnel and Compensation, House Committee on Armed Services, asked us to determine (1) what progress VA and DOD have made in implementing Public Law 97-174, (2) whether opportunities for sharing health care resources between the two agencies have been maximized, (3) whether current incentives to encourage sharing are adequate, (4) whether any obstacles interfere with the initiation of sharing arrangements, and (5) whether any administrative or legislative changes are needed to further encourage sharing.

VA and DOD Health Care Delivery Systems

VA and DOD provide health care directly to eligible beneficiaries through separate systems of hospitals and clinics. The combined systems' U.S. operations include more than 300 hospitals and 600 outpatient clinics. The two agencies had combined direct care budgets of nearly $20 billion in fiscal year 1987, including construction programs for both and overseas activities for DOD. Both systems also pay civilian health care providers for medical care to their beneficiaries. The agencies' combined annual payments to civilian providers were over $2 billion in fiscal year 1987.

The VA health care system has three objectives: to provide quality medical care to veterans, to educate and train medical personnel, and to conduct research. Before July 1986, VA medical care was available to eligible veterans on a space-available basis, and veterans with service-connected disabilities were given the highest priority for care. However, under title XIX of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272), VA is now required to provide hospital care for certain categories of veterans, including those with service-connected disabilities and those unable to defray the costs of their care. In addition, the act states that VA may provide hospital care on a space-available basis to other eligible veterans if they agree to pay the applicable cost of their care. The DOD health care system has two primary objectives. The first, the readiness mission, is to maintain the health of the active duty

force of the uniformed services[1] and be prepared to attend the sick and wounded in wartime. The second, the peacetime benefit mission, is to provide medical care to eligible dependents and retirees when space, facilities, and staff are available. Active duty members of the uniformed services have first priority for care in military medical facilities, and their eligibility has no conditions attached. Care provided in military treatment facilities to other uniformed services' beneficiaries—dependents of active duty members, military retirees and their dependents, and dependents of deceased members—is provided on a space-available basis. DOD's direct health care delivery system is composed of three separate systems administered by the Surgeons General of the Army, Navy, and Air Force.

Table 1.1 illustrates the magnitude of VA's and DOD's direct hospital and clinic operations within the United States during fiscal year 1986.

Table 1.1: VA and DOD Hospitals and Clinics, Fiscal Year 1986

Hospital discharges and clinic visits in thousands

System	Number of Hospitals	Clinics	Hospital discharges	Clinic visits
VA	172	228	1,274	18,451
DOD	132	394	780	35,357
Total	**304**	**622**	**2,054**	**53,808**

In addition to their direct care systems, both VA and DOD pay large amounts for medical care for their beneficiaries at other than their own facilities. During fiscal year 1986, combined VA and DOD payments to nonfederal medical providers were over $1.95 billion. About 90 percent of these expenditures were for the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), which is administered by DOD. CHAMPUS provides medical care from civilian sources to dependents of active duty members, retirees, dependents of retirees, and dependents of deceased members. In fiscal year 1987, the CHAMPUS budget was about $2 billion.

VA/DOD Sharing of Health Care Resources

The Economy Act (31 U.S.C. 1535) and legislation permitting the sharing of VA specialized medical resources (38 U.S.C. 5053) with other federal and nonfederal health care providers gave federal agencies the

[1]The uniformed services include the Army, Navy, Air Force, Marine Corps, Coast Guard, and Commissioned Corps of the Public Health Service and of the National Oceanic and Atmospheric Administration.

authority to share health care resources. Until the enactment of Public Law 97-174, however, no legislation specifically encouraged sharing between VA and DOD. Accordingly, until the 1982 legislation, VA and DOD did not establish an effective sharing program, in part because of restrictive agency policies and regulations. Consequently, medical facilities lacked incentives to share. As a result, opportunities to share resources in VA and DOD hospitals were forgone, and savings or other benefits were lost.

For example, as we reported in 1978, many opportunities for greater sharing of medical resources among federal agencies—particularly VA and DOD—were not considered, had been pursued but abandoned, or had been only partially successful.[2] We found that the following obstacles precluded attempts by, or discouraged, federal officials from completing satisfactory interagency sharing arrangements.

- The lack of both a specific legislative mandate for interagency sharing and adequate headquarters guidance on how to share.
- Restrictive agency regulations, policies, and procedures.
- Inconsistent and unequal methods for reimbursing agencies for services rendered to other agencies' beneficiaries.

Public Law 97-174

To promote greater sharing of health care resources between VA and DOD, on May 4, 1982, the Congress enacted Public Law 97-174.[3] The law authorizes the head of each VA and DOD medical facility to enter into sharing agreements with the heads of medical facilities of the other agency. The act's legislative history emphasizes that, to be successful, sharing agreements should be developed at the local level with a minimum of headquarters involvement. Accordingly, the act stipulates that a sharing agreement negotiated by local DOD and VA officials is to go into effect automatically unless disapproved by higher headquarters officials within 46 days.

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

[3]The law also directed the Secretary of Defense and the Administrator of Veterans Affairs to plan for VA to provide health care during periods of war or national emergency to members of the armed forces on active duty and in certain other situations. Since this aspect of the law was outside the scope of the Chairman's request, we did not address it during this review.

Public Law 97-174 required the Administrator of Veterans Affairs and the Secretary of Defense to jointly establish guidelines to promote sharing of health care resources between their agencies. In a July 1983 memorandum of understanding, the Administrator and Secretary established the VA/DOD Health Care Resources Sharing Guidelines. The guidelines strongly encourage maximization of sharing opportunities, stating that greater sharing will enhance benefits for veterans and members of the armed services and will reduce costs to the government by minimizing duplication and underuse of health care resources.

To promote the sharing of health care resources between VA and DOD, the sharing act established the Veterans Administration/Department of Defense Health Care Resources Sharing Committee. The committee is composed of VA's Chief Medical Director, the Assistant Secretary of Defense (Health Affairs), and other agency officials designated by them.

VA and DOD also designated other officials to help promote and monitor sharing activities. VA's Emergency Management and Resource Sharing Service helps to promote sharing within that agency. The Office of the Assistant Secretary of Defense (Health Affairs) has designated a senior officer in its Medical Resources Administration office to carry out a similar role within DOD. In addition, the Army, Navy, and Air Force have been given responsibility for reviewing sharing proposals submitted by their respective hospitals. The armed services' offices that review sharing proposals or provide guidance on sharing include the Offices of the Air Force Surgeon General and Naval Medical Command, Washington, D.C., and U.S. Army Health Services Command, Fort Sam Houston, Texas.

Implementation of Public Law 97-174 began in October 1983, when VA and DOD initiated a series of sharing orientation workshops attended by representatives of local VA and military hospitals. During the workshops, attendees discussed how best to plan, negotiate, and conduct shared service arrangements.

Objectives, Scope, and Methodology

Our review focused on the peacetime VA/DOD sharing program. We did not examine VA/DOD planning for wartime or national emergencies, since the Chairman did not ask us to examine this aspect of Public Law 97-174.

To learn about sharing program guidelines, interpretations of the act's sharing provisions, and views about the program's progress, we contacted officials in VA and DOD offices who are responsible for implementing and monitoring sharing activities. We contacted DOD's Office of the Assistant Secretary of Defense (Health Affairs); the Offices of the Surgeons General of the Army, Navy, and Air Force; the Naval Medical Command; and VA's Central Office, including the Emergency Management and Resource Sharing Service. Our work with agency officials was generally conducted at their headquarters offices in the Washington, D.C., area. We also visited the Army's Health Services Command in San Antonio and the Naval Medical Command's Southwest Region in San Diego, California, and Northeast Region in Great Lakes, Illinois.

To learn about sharing activities at the field level, we reviewed sharing agreements and other program information at VA's and DOD's headquarters offices. Because only limited information about sharing at specific facilities was available at these offices, we also conducted telephone interviews with chief administrators or other officials at 68 Army, Navy, Air Force, and VA medical facilities in the United States. We discussed with these officials (1) the scope of sharing activities, if any, in their local areas; (2) other possible opportunities for sharing at their facilities; (3) the adequacy of sharing incentives; (4) whether sharing obstacles exist, and (5) why sharing efforts (if any) had succeeded or failed at their facilities.

To further develop information on sharing activities in specific areas, we judgmentally selected 25 of the 68 medical facilities contacted by telephone for site visits (see app. I). The hospitals and clinics we visited included facilities that had sharing agreements that VA or military officials considered successful (i.e., officials told us the agreements had resulted in savings, improved patient access to specialized services, or produced other benefits). We also visited facilities that had no sharing agreements at the time of our visits or had agreements that VA or military officials had told us were mostly inactive (i.e., the services in the agreements were not actually being shared). Our site visits were conducted from February through December 1986. The facilities visited ranged from small freestanding clinics to large teaching hospitals.

Because of the significant additional audit work that would have been required, we generally did not attempt to calculate the total savings attributable to sharing activities at specific medical facilities. Our audit work was conducted in accordance with generally accepted government auditing standards.

Progress Made in Sharing Medical Resources

VA and DOD have made significant progress in sharing federal medical resources. The sharing program began to be implemented in early fiscal year 1984. As of September 1986, the two agencies had about 240 sharing agreements in effect. VA and DOD hospital officials have identified benefits associated with the use of agreements, such as reduced federal health care expenditures and improved patient access to specialized services. In addition, VA and the Air Force have developed two precedent-setting agreements involving the joint use of hospitals that could serve as models for the effective use of existing health care facilities or those to be built in the future.

Increase in Sharing Activities After Passage of Public Law 97-174

Public Law 97-174 has promoted greater sharing of health care resources between VA and DOD. Since the program began to be implemented early in fiscal year 1984, the number of sharing agreements entered into under the act's authority has increased steadily.

Table 2.1 shows that increasing numbers of VA and DOD facilities have become involved in such agreements since the program's inception.

Table 2.1: Number of Facilities With Sharing Agreements, Fiscal Years 1984-86[a]

Fiscal Year	VA	Army	Navy	Air Force	Total
1984	52	20	8	22	**102**
1985	76	37	12	31	**156**
1986	101	64	22	51	**238**

[a]Some facilities had one agreement for several shared services, while others negotiated separate agreements for each shared service. Also, some facilities had agreements with more than one of the other agency's facilities

In addition to the local agreements summarized in the table, VA and DOD entered into a national sharing agreement in June 1986. The agreement both establishes nationwide referral procedures for active duty emergency patients and enables all VA facilities that treat active duty emergency patients to be directly reimbursed by DOD.

VA/DOD sharing activities have involved various inpatient and outpatient services and various types of facilities, ranging from freestanding outpatient clinics to teaching hospitals. VA has provided services to DOD ranging from laundry to open-heart surgery, while DOD has provided such services as laboratory testing and gynecology care. In June 1986, VA's Chief Medical Director testified before the Subcommittee on Oversight and Investigations, House Committee on Veterans' Affairs, that the

most frequently shared service is diagnostic testing (e.g., laboratory and radiology services).

Data compiled by VA further illustrate the extent of the sharing program. As of June 1986, every VA medical center within 25 miles of a military medical facility had at least one medical resource being shared. Of the VA medical centers within 50 miles of a military medical treatment facility, only six were not involved in sharing with a military facility.

Neither VA's Emergency Management and Resource Sharing Service nor the Office of the Assistant Secretary of Defense (Health Affairs) routinely collects data on reductions in federal health care costs associated with sharing agreements. Nevertheless, information compiled by VA and DOD medical headquarters offices on selected sharing activities, and information we obtained during interviews with VA and DOD hospital officials, indicate that hospitals have reduced their expenditures through sharing. For example, officials at several hospitals told us that sharing enabled their facilities to reduce costs since federal hospitals in their areas could provide laundry, laboratory, medical, or other services more economically than private sources.

Several VA and DOD hospital officials also told us that sharing agreements improved beneficiaries' access to certain medical services, such as open-heart surgery and radiology procedures. In many cases, local VA or DOD hospitals could provide more convenient access to the services than other federal or private providers, the officials stated.

VA and Air Force Joint Hospital Ventures

VA and the Air Force are developing two pilot projects—in Albuquerque, New Mexico, and Las Vegas, Nevada—involving the joint use of inpatient facilities. The projects are intended to avoid duplication of medical facilities and curtail federal hospital construction expenditures. VA/DOD studies of joint ventures are also underway in Anchorage, Alaska; Tucson, Arizona; and El Paso, Texas.

Albuquerque Project

In Albuquerque, New Mexico, VA and the Air Force have developed a joint venture under which the Air Force will lease the sixth floor of the new Albuquerque VA Medical Center. The sixth floor will be designated an Air Force medical facility, and the floor's 40 primary care beds will be staffed by Air Force medical personnel. The Air Force will reimburse

the VA medical center for specialized medical and ancillary services furnished to DOD beneficiaries. Also, the Air Force will construct an outpatient clinic adjacent to the VA medical center that will provide primary care outpatient services to DOD beneficiaries. This is the first project of its type between VA and DOD.

The Albuquerque joint venture should provide significant economic and noneconomic benefits to both VA and the Air Force. For example, because of the venture, the Air Force will not replace the 45-bed hospital at Kirtland Air Force Base (located 2 miles from the VA medical center), thereby saving about $10 million. According to the deputy director of VA's Emergency Management and Resource Sharing Service, VA overestimated VA beneficiaries' need for inpatient services when the new Albuquerque hospital was planned; consequently, it can accommodate Air Force patients without adding space. Furthermore, the director of the Albuquerque VA Medical Center believes the entire VA and Air Force beneficiary community will benefit from the venture since health care would be delivered in new facilities, containing state-of-the-art technology, including a full range of primary, secondary, and specialized care. Currently, services at Kirtland Air Force hospital are limited generally to outpatient care.

Las Vegas Project

Another joint venture by VA and the Air Force involves medical facilities in the Las Vegas, Nevada, area. The project will involve VA/Air Force sharing of $69.6 million in construction costs to replace the hospital at Nellis Air Force Base. The Air Force will pay $58.7 million of the costs, while VA will pay the remaining $10.9 million. The new 135-bed Air Force hospital (83 Air Force beds and 52 VA beds) will provide inpatient services to beneficiaries of both VA and the uniformed services, while the existing freestanding VA outpatient clinic will continue to provide most of the outpatient care required by VA beneficiaries.

According to VA officials, the Las Vegas venture should provide significant benefits to both VA and the Air Force. A major benefit to VA beneficiaries will be improved access to inpatient care since the closest VA medical center is 240 miles away. In addition, VA and the Air Force believe a new hospital will reduce beneficiaries' reliance on private medical providers and result in overall reductions in federal health care costs. CHAMPUS and VA payments to private hospitals and physicians in the Las Vegas area for medical services that could not be provided by DOD or VA totaled $11.5 million in fiscal year 1986. Furthermore, the

director of the Las Vegas VA Outpatient Clinic has stated that a new hospital serving combined VA/Air Force needs will more readily justify the provision of specialized services and "high-tech" systems that would not be justified by the Air Force or VA workload alone.

Conclusions

In our opinion, the guidance and procedures contained in Public Law 97-174 have enabled VA and DOD officials to implement greater sharing of health care resources. Such sharing has not only resulted in monetary savings, but has improved federal beneficiaries' access to medical services. The ongoing development of joint hospital ventures should help the government avoid costly and unnecessary duplication of federal medical facilities, staff, and equipment.

Problems With Reimbursement Rates Hinder Sharing Activities

Before the enactment of Public Law 97-174, reimbursements for shared services between federal agencies were based on "actual" (or total) costs, including both the incremental costs attributable to providing the shared services and a portion of the providing facility's fixed costs not so attributable, such as depreciation and overhead costs. Reimbursement policies based on these "average actual" (total) costs represented a substantial impediment to the interagency sharing of federal medical resources.[1] The developers of Public Law 97-174 recognized this obstacle and specifically permitted reimbursement rates between VA and DOD facilities that took into account both local conditions and the costs of the services being shared.

VA and DOD hospital officials need to have flexibility in negotiating reimbursement rates if the benefits of sharing are to be realized fully. When excess capacity exists, greater utilization of the existing capacity will not increase the facility's fixed costs. As long as reimbursement rates are set high enough to recover incremental costs, sharing can lead to more effective utilization of the facility and may allow the agencies to treat federal beneficiaries at rates substantially below what they would otherwise pay for such treatment in the private sector. When reimbursement rates are set at a level that reflects total costs, sharing of excess capacity may be discouraged, and the agencies may find that using private sector facilities costs the agency less even in situations where it results in a higher total cost to the government. Our current review showed that sharing agreements have continued to be hindered or prevented from being developed because officials at several VA and DOD hospitals were not aware that reimbursement rates below total costs are permitted by Public Law 97-174.

Reimbursement Rates Below Total Costs Are Allowed

Public Law 97-174 states that reimbursement under any VA/DOD sharing agreement shall be based upon a methodology that is agreed upon by VA's Chief Medical Director and the Assistant Secretary of Defense (Health Affairs) and

"... that provides appropriate flexibility to the heads of the facilities concerned to take into account local conditions and needs and the actual costs to the providing agency's facility of the health care resources provided."

[1]HRD-78-54, p. 32

In response to Public Law 97-174, the Administrator of Veterans Affairs and Secretary of Defense issued the VA/DOD Health Care Resources Sharing Guidelines in August 1983. According to the guidelines, "reimbursement rate" is defined as the negotiated price cited in a sharing agreement for a specific health care resource. The guidelines state, as the act does, that reimbursement rates will take into account local conditions and needs and actual costs. The guidelines further state that actual cost includes the cost of communications, utilities, services, supplies, salaries, depreciation, and related expenses connected with providing health care resources. However, the guidelines encourage facilities to exclude equipment depreciation from reimbursement rates. Also, heads of medical facilities may negotiate a rate that is less than actual cost to the providing facility or organization to account for local conditions and needs, the guidelines state.

Hospital Officials Unaware of Reimbursement Rate Policy

Officials at several hospitals held views about reimbursement rates that conflicted with the reimbursement rate policy in the VA/DOD Health Care Resources Sharing Guidelines allowing rates below actual costs. These conflicting views resulted because the officials were not aware of the guidelines or the guidelines were inconsistent with other agency guidance on reimbursement rates.

At the St. Louis VA Medical Center, for example, the chief of fiscal service said he relied on guidelines for sharing specialized medical resources under 38 U.S.C. 5053 to determine how rates for a proposed agreement with Air Force Scott Medical Center should be developed. These guidelines are distinct from the Public Law 97-174 guidelines established in August 1983. The guidelines for sharing under 38 U.S.C. 5053 require VA medical facilities to recover the full (actual) costs of tests or procedures they provide under sharing agreements for specialized medical resources. The chief of fiscal service said he did not become aware of a VA circular relating to the VA/DOD sharing program until May 1986.

At the Charleston, South Carolina, Naval Hospital, a contracting officer was also unaware of the reimbursement policy in the VA/DOD sharing guidelines. Furthermore, he said use of the term "actual costs" in Public Law 97-174 was the major reason why he believed military hospitals must recover total costs from VA, even if they have excess capacity. He believed the law also requires VA to recover total costs when providing services to DOD. Because he perceived that rates based on total costs were usually equivalent to prices charged by civilian providers, he saw

few opportunities for the naval hospital to save money through sharing, even though the nearby VA medical center had excess capacity in several medical departments.

The three military services have reimbursement rate guidelines, but only the Air Force provides clear authority to hospitals to allow reimbursement rates below total costs. Army and Navy guidance on reimbursement rates do not authorize lower rates.

Reimbursement Rate Problems Discouraged Sharing

When reimbursement rates based on total costs exceed prices available in the private sector, VA and DOD medical facilities may have no incentive to share each other's underused medical services. Instead, federal capacity remains underused, while care is provided from a local health care provider in the private sector.

This was the situation, for example, in the Long Beach, California, and Syracuse, New York, areas. Military hospitals in these areas—Long Beach Naval Hospital and Griffiss Air Force Base Hospital, Rome, New York—decided to obtain services from civilian sources rather than sharing after VA medical centers had proposed reimbursement rates based on total costs that were higher than prices offered by civilian providers. Communication problems between VA and DOD hospital officials and other nonfinancial factors may also have discouraged sharing.

Long Beach Naval Hospital Sharing Agreement Not Used

Although the naval hospital successfully negotiated a sharing agreement with the Long Beach VA Medical Center for some medical services, the naval hospital decided not to use VA for computerized tomography (CT) procedures because use of a private contractor was more economical. In addition, the naval hospital's chief of radiology preferred the private contractor because he believed the contractor offered easier access to CT scans and would enable Navy physicians to maintain better control over patients. The Navy contractor would park a van containing a mobile scanner next to the hospital, no appointments for CT scans would be necessary, and Navy physicians could easily monitor patient reactions to the scans. On the other hand, using VA could require ambulance transfer of inpatients to the VA medical center, appointments would generally be required, and Navy physicians could lose some control over the patients.

We compared average CT scan prices paid for four CT procedures by the naval hospital using a private contractor to the rates it would have paid

if it had used the Long Beach VA Medical Center. Three of the four medical center rates were 30 to 48 percent higher than the average prices charged by the private contractor. The center's rates ranged from $235 to $428, while the contractor's prices ranged from $236 to $327.

In our opinion, it is questionable whether Long Beach VA Medical Center reimbursement rates for CT scans had to be higher than the prices charged by the naval hospital's private contractor. VA's Fiscal Service records show that the reimbursement rates were developed by calculating direct labor and personnel expenses for each CT scan category and allocating depreciation, administrative, and other indirect expenses among the different types of scans.

The administrative officer of the VA center's radiology service and the assistant chief of Fiscal Service told us they assumed CT scan rates had to be based on total costs. According to the Fiscal Service official, he followed VA guidelines on reimbursement rates for specialized medical resources, and was unaware of VA's policy permitting rates for VA/DOD sharing agreements to be set below total costs. Each scan included, among other costs, $150 per scan for administrative support and quality assurance/quality control. The administrative officer also said the medical center would probably not have to hire additional radiologists to handle the expected Navy CT scan workload. Both officials agreed that it would make more sense to calculate reimbursement rates excluding VA's fixed costs, such as quality assurance and administrative support, in order to make the rates competitive with those charged by the private contractor.

Excluding just the $150 in administrative support and quality assurance/quality control costs from VA's rates would have brought them significantly below the private contractor's prices. Excluding these expenses would have made the VA medical center's rates 4 to 74 percent below the prices charged by the civilian contractor, depending on the type of scan. Excluding other VA expenses that would not be affected by the Navy workload (such as radiologist salaries) would have lowered VA's rates even further.

We estimated that the Navy could have saved over $17,000 during a 3-month period (Oct.-Dec. 1985) we examined by obtaining CT scan services from the VA medical center instead of the civilian contractor, according to the adjusted reimbursement rates. While we did not attempt an in-depth analysis of the nonfinancial considerations that affected the Navy's decision to use a private contractor instead of VA, we

considered one of the chief of radiology's concerns about ease of patient access. We found that most of the Navy scans (86 percent) were performed on outpatients. Consequently, it would not have been necessary to transfer many inpatients to the VA medical center.

Griffiss Air Force Base Hospital Proposed Sharing Agreement With VA Abandoned

For about 2 years, officials at the Syracuse VA Medical Center and the Griffiss Air Force Base hospital held discussions about developing a sharing agreement. Among other services, Griffiss considered using the VA medical center's laundry service instead of a private vendor. The VA medical center had excess capacity in its laundry service, and VA officials believed that such sharing could generate additional funds for medical center programs. Despite repeated efforts, however, sharing negotiations were unsuccessful, and as of August 1987, the hospitals had no sharing agreement in effect.

A cost comparison conducted by Syracuse's VA laundry plant manager showed that Griffiss' laundry costs using the VA medical center would be virtually the same as its costs under the commercial contract—about $27,000 annually. The director of Medical Logistics at Griffiss noted, however, that the private contractor transported linen to and from Griffiss as part of the contract, whereas the VA medical center did not offer transportation as part of the proposed sharing agreement. Consequently, the higher transportation costs associated with a sharing agreement made use of the VA laundry services uneconomical. As a result, negotiations with Syracuse VA to share laundry services were terminated in January 1986.

According to Syracuse VA building management service officials, the proposed reimbursement rates for laundry services were based on total costs, including labor and fringe benefits, as well as utilities, equipment maintenance, and supplies. Syracuse VA's laundry service had substantial excess capacity. During fiscal year 1985, about 334,000 (or about 28 percent) of the total 1.2 million pounds of total laundry plant capacity was unused. Griffiss' laundry workload averaged 145,000 pounds annually.

We asked Syracuse VA officials why, given the significant excess capacity in the laundry plant, proposed reimbursement rates for laundry services were based on total costs instead of only the additional costs to provide the service. The chief of the Supply Service, who conducted sharing negotiations, told us he did not provide any guidance to building

management service officials on how to develop the proposed reimbursement rates. However, he assumed the rates they developed were appropriate for sharing negotiations. Building management service officials, including the laundry section supervisor, stated that the proposed reimbursement rates were developed using laundry cost data collected for a study comparing the cost of performing laundry services in house to the cost of a private contractor. The officials stated that Office of Management and Budget (OMB) guidelines require the use of total costs in such studies, and they assumed that total costs should also be used to develop proposed reimbursement rates for VA/DOD sharing agreements. They told us they were not aware of any reimbursement guidelines specific to VA/DOD sharing agreements.

Syracuse VA building management service officials agreed that in view of the excess capacity in the laundry plant, absorbing Griffiss' laundry workload would have little or no effect on plant operating expenses. They emphasized that, had they known it was not necessary for reimbursement rates to be based on total costs, they would have proposed lower rates to make it worthwhile for Griffiss to enter into a sharing agreement. The administrator of Griffiss told us he assumed during sharing negotiations that reimbursement rates for laundry services had to be based on total costs. Consequently, he did not attempt to negotiate downward Syracuse VA's proposed reimbursement rates for laundry services.

Conclusions

Potential medical resource sharing activities between VA and DOD have not taken place because of facilities' adherence to reimbursement rate guidelines established for sharing medical resources under the Economy Act and 38 U.S.C. 5053, rather than those established for implementing Public Law 97-174. Reimbursement rates under the Economy Act and 38 U.S.C. 5053 are required to be established on the basis of total costs; rates for medical resources sharing under Public Law 97-174 are not so required. Public Law 97-174 and the VA/DOD Health Care Resources Sharing Guidelines are flexible, allowing considerable latitude in setting reimbursement rates. However, this flexibility in establishing rates to encourage sharing between VA and DOD facilities is not understood by local hospital officials who negotiate the sharing agreements. Sharing program guidance should be clarified to emphasize that rates below total cost are allowable and encouraged for VA/DOD sharing agreements.

Recommendations

We recommend that the Administrator of Veterans Affairs and the Secretary of Defense enhance VA and DOD medical sharing opportunities by notifying each of their medical center directors, hospital commanders, and audit and inspection organizations that, under the VA/DOD Health Care Resources Sharing Guidelines, reimbursement rates may be locally negotiated at less than total cost.

Agency Comments and Our Evaluation

DOD Comments

DOD gave us official oral comments on a draft of this report during a meeting on October 30, 1987. The Department partially concurred in our recommendation that it notify appropriate personnel that reimbursement rates may be negotiated at less than total cost. DOD officials stated, however, that language in Public Law 97-174 relating to establishment of reimbursement rates has led to different interpretations and needs to be clarified before such notification should take place.

We believe DOD already has sufficient authority to negotiate reimbursement rates at less than total cost and that no clarification of the wording in Public Law 97-174 is necessary. As discussed on page 18, both the Administrator of Veterans Affairs and the Secretary of Defense stated in August 1983 (in the VA/DOD Health Care Resources Sharing Guidelines) that rates may be negotiated at less than total cost. We believe this interpretation of Public Law 97-174 was reasonable since the Congress directed that reimbursement under any VA/DOD sharing agreement be based on a methodology agreed upon by VA's Chief Medical Director and the Assistant Secretary of Defense (Health Affairs). In this regard, the act states that the reimbursement methodology should provide appropriate flexibility to the heads of facilities concerned to take into account local conditions and needs, as well as costs to the providing agency's facility of the resources provided. A principal objective of Public Law 97-174 is to encourage greater sharing of health care resources and remove obstacles to sharing. The act's legislative history shows that the Congress was aware that inflexible reimbursement rate policies had discouraged sharing activities between VA and DOD in the past.

VA Comments

In a letter dated November 24, 1987, VA concurred in our recommendation. (See app. II.) VA said that the Department of Medicine and Surgery's (DM&S's) Medical and Operational Activities Manual will be revised to clarify the issue of reimbursement methodology and will state that reimbursement rates may be negotiated at less than actual costs.

OMB Comments

In November 17, 1987, letter commenting on a draft of this report, OMB stated that the Secretary of Defense and the Administrator of Veterans Affairs should move cautiously in pricing the services they provide to each other below full costs. (See app. III.) OMB was concerned that setting reimbursement rates below total costs will understate the cost of providing care to DOD beneficiaries in the DOD budget and will result in VA providing a direct subsidy to the DOD medical system. Further, OMB stated, reimbursements reflecting less then total costs may lead DOD to neglect other use of its resources, such as civilian contracting or incremental additions to its own program, which may have costs lower than VA's. OMB specifically cited care provided under CHAMPUS where, because of beneficiary cost-sharing requirements, the government pays only a portion of total costs.

We do not agree that establishing reimbursement rates below total costs would constitute a VA "subsidy to the DOD medical system." In our opinion, OMB's position conflicts with congressional intent. The legislative history of Public Law 97-174 shows that the Congress expected the reimbursement rates to be based on local conditions so that sharing activities could be maximized. OMB's position, which is shared by neither VA nor DOD, would cause a curtailment of future sharing opportunities and increase costs to the government since needed services may have to be acquired from the private sector at higher prices. This is what happened at several locations we visited.

Finally, OMB provided no information to support its contention that DOD may neglect other use of its resources, including civilian contracting or incremental additions to its own program, or CHAMPUS, which may have lower costs than VA. A fundamental premise of the VA/DOD sharing program is that sharing arrangements between the two agencies will occur only if such sharing is the most cost-effective means of providing care to federal beneficiaries on a space-available, referral basis. Such sharing arrangements, therefore, were meant to maximize savings to the government. We believe that a prudent commander of a military medical facility, faced with a finite supply of resources, would not enter into a sharing agreement with a VA facility if it would result in costs higher

than those that would be incurred if the services were obtained from non-VA sources.

DOD's Treatment of Reimbursements Does Not Provide Sharing Incentive as the Law Intended

Public Law 97-174 requires that medical facilities be reimbursed for services they provide under VA/DOD sharing agreements. The purpose was to create an incentive for VA and DOD medical facilities to share their medical resources.

However, the methods followed by VA and DOD to handle reimbursements differ significantly. VA medical centers promptly receive credit for all sharing reimbursements they earn, and their budgets are not reduced by the sharing amounts they receive. In contrast, military health care facilities do not directly receive additional budgetary resources when they are paid by VA for treating veterans under sharing agreements. DOD officials stated that DOD and the services provide military personnel staffing and operating budget allotments to hospitals in advance to cover their anticipated workloads, including reimbursable work under sharing agreements. Accordingly, DOD hospitals are not permitted to retain the reimbursements they receive for services provided to VA. However, because the original budget allotments provided to DOD hospitals do not identify the personnel and operating funds provided to cover sharing agreement work, local hospital managers do not know if, and to what extent, they are being funded for that work. Accordingly, they believe they have little incentive to perform such work for VA.

The reimbursement mechanism established by VA has created an incentive for its hospitals to share their resources, while DOD's treatment of sharing reimbursements has discouraged military hospitals from providing services to VA. To alleviate its hospital managers' concerns regarding the lack of incentives to share resources with VA, DOD should explicitly inform its managers of the amounts of anticipated sharing reimbursements with which they are being credited during the DOD budget development process.

Sharing Law Established Reimbursement Incentives

Public Law 97-174 provides, in part, that under any VA/DOD agreement

- ". . . a providing agency shall be reimbursed for the costs of health care resources provided under the agreement . . .", and
- ". . . any funds received through such a reimbursement shall be credited to funds that have been allotted to the facility that provided the care or services."

After the law was enacted, both VA and DOD affirmed their intentions to adhere to the congressional mandate for allocating sharing reimbursements to medical facilities that provided the services. In August 1983,

the Administrator of Veterans Affairs and the Secretary of Defense signed a memorandum of understanding establishing the VA/DOD Health Care Resource Sharing Guidelines. Section 3-104 of the guidelines states that:

"Reimbursement for the cost of health care resources provided shall be credited to funds that have been allotted to the facility or organization that provided the care or services. The medical facility or organization providing the resources shall bill the recipient facility or organization directly. . . . Reimbursement shall be forwarded to the providing medical facility in a timely manner."

The legislative history of Public Law 97-174 shows that the purpose of the reimbursement requirement was to provide facilities with an incentive to share health care resources. For example, in the pertinent Senate report (S. Rep. No. 97-137 (1981)), the Senate Committee on Governmental Affairs stated that the reimbursement provision was the most important incentive for interagency sharing. The Committee stated that it was crucial to the success of the sharing program that the providing facility be reimbursed directly and promptly for services provided under sharing arrangements.

VA's Reimbursement Practices Provide Incentives to Share; DOD's Do Not

VA and DOD have adopted substantially different procedures for treating reimbursements to facilities that enter into sharing agreements under Public Law 97-174. While both agencies reimburse their facilities for proceeds received under sharing agreements, VA's procedures permit facilities to be credited for all of these proceeds, while DOD's procedures require that a portion of the proceeds be deposited directly into centrally managed personnel accounts. Also, according to DOD officials, during the formulation of DOD hospitals' operations and maintenance budgets, obligational authority is provided for reimbursable work, including that expected to be performed under Public Law 97-174 sharing agreements. Consequently, as DOD hospitals receive reimbursements for services provided to VA beneficiaries under sharing agreements, their operating funds are reduced by the amounts of these proceeds.

The effect of the different VA and DOD reimbursement ractices regarding sharing activities and incentives is notable. VA's reimbursement mechanism gives facilities an incentive to share their services because VA hospital managers know that they will be credited with all sharing reimbursements they earn and their budget allocations will not be affected. On the other hand, DOD's treatment of sharing reimbursements does not give facilities a similar incentive because DOD hospital managers

(1) know that they will not be credited with the military pay portion of the reimbursements they receive from VA and (2) are unaware of the amounts of obligational authority, if any, with which they were initially credited for expected sharing reimbursements. In addition, DOD hospital managers recognize that their obligational authority will be reduced by the amounts of reimbursements related to operations and maintenance they receive from VA.

VA's Treatment of Sharing Reimbursements Gives Medical Centers Incentives to Share

According to DM&S guidelines, VA medical centers are entitled to retain all reimbursements earned from services provided to DOD under Public Law 97-174. Procedures for carrying out this policy have been in effect since September 1983.

DM&S Circular 10-84-148 (Instructions for Implementing the Sharing Provisions of Public Law 97-174) permits VA facilities to recover and use the entire amount of sharing reimbursements received from DOD medical facilities. These reimbursements are deposited in a VA central office account, and VA medical centers may request to be credited for the reimbursements. Fiscal Service officials at the VA medical centers we visited stated that their requests for sharing reimbursements were always promptly honored by the central office, and their budgets were not reduced by the amounts of the reimbursements.

VA's reimbursement mechanism gives VA medical centers an incentive to provide services to DOD. The Nashville VA Medical Center, for example, collected about $392,000 in sharing reimbursements during fiscal years 1985 and 1986. The reimbursements were generated largely by providing CT scans and other services to patients at Colonel Florence A. Blanchfield Army Community Hospital, Fort Campbell, Kentucky. Nashville VA officials, including the director, stated that the reimbursements benefited medical center programs and helped the center meet the needs of the growing VA beneficiary population during a time of tight budgets. Nashville's associate director, who was familiar with the armed services' procedures not allowing facilities to retain reimbursements, told us that such procedures, if imposed on VA medical centers, would "kill" VA participation in the sharing program.

Officials at the Salt Lake City VA Medical Center told us that, in the past, the lack of excess capacity and other obstacles had severely limited the center's ability to share its services with local military medical facilities. The officials stated, however, that the ability to retain sharing reimbursements opened up a variety of sharing opportunities that could

potentially benefit both VA and DOD beneficiaries. VA could benefit because reimbursements could be used to expand services at the medical center for veterans; DOD could benefit because reimbursements would enable VA to also expand services for military beneficiaries at the Salt Lake City center—the only large (403-bed) federal hospital in Utah offering a wide variety of specialized services.

DOD's Treatment of Sharing Reimbursements Does Not Give Hospitals Sharing Incentives

Based on our review of the military services' guidelines and military hospital procedures, as well as interviews with financial management and medical headquarters officials, we identified the following basic budget and accounting procedures that affect sharing reimbursements collected by Army, Navy, and Air Force hospitals.

1. Individual hospitals provide higher command offices with historical workload statistics (including data on workload generated because of sharing activities) and estimates of the reimbursement for sharing anticipated for the upcoming fiscal year.

2. Higher commands determine military personnel and O&M requirements for hospitals based on historical workload statistics and systemwide budget constraints. These requirements are intended to reflect all of the hospitals' activities, including sharing activities. Military personnel are provided to hospitals based on requirement determinations and are paid from centralized armed service accounts. Hospitals are provided funding to cover O&M activities. During the process of developing hospitals' O&M budgets, services' medical commands provide each hospital obligational authority to fund its anticipated reimbursable work, including that under sharing agreements.

3. Hospitals separate sharing reimbursements they collect into (a) military pay (typically two-thirds of the total) and (b) O&M (typically one-third of the total). The military pay portion of collected reimbursements is deposited into one of the centrally managed military pay appropriation accounts. The military pay portion is not retained by the hospital since military pay is centrally funded. Hospitals' O&M budgets are reduced by the amounts of the O&M portions of the reimbursements since, according to DOD financial management officials, the facilities had been provided initial obligational authority for reimbursable workload during the budget development process.

In January 1987 we met with financial management officers and other officials from the medical headquarters offices of the Army, Navy, and

Air Force to discuss the armed services' reimbursement and budget procedures. In addition, we met with officials from the Office of the Assistant Secretary of Defense (Comptroller), including the office's director for accounting policy. The officials generally stated that the reimbursement and budget procedures we identified reflected long-standing DOD financial practices and were not unique to the VA/DOD sharing program.

In contrast to the VA situation, the armed services' reimbursement procedures are perceived by military hospital managers as providing little financial incentive to share services with VA. For example, the comptroller of the Great Lakes Naval Hospital in Illinois said Navy hospitals could provide some services to VA when they had excess capacity. He stated, however, that potential sharing opportunities that required additional incremental outlays for personnel, equipment, or other resources would generally be impractical because sharing reimbursements generally would not result in a prompt increase in the hospital's operating funds or military personnel allocations. Consequently, there would be no practical way to offset any additional expenses associated with sharing.

The adverse effects on sharing resulting from the armed services' reimbursement procedures were evident at military hospitals we visited in Alaska and Hawaii, the only states where VA does not operate an inpatient facility. In both states, VA has used military hospitals for inpatient services, but staffing limitations and other resource constraints have limited the hospitals' ability to care for veterans. Officials at the military hospitals stated that sharing reimbursements did not benefit their facilities or enhance their ability to expand services for veterans. Consequently, VA has found it necessary to refer many veterans to civilian hospitals in Alaska and Hawaii and, in some cases, to its own facilities in the continental United States.

Elmendorf Air Force Regional Hospital

The administrator of the U.S. Air Force Regional Hospital, Elmendorf Air Force Base, Alaska, told us that VA sharing reimbursements collected by Elmendorf did not give the hospital an incentive to provide additional services to VA. During a 6-month period from January through June 1986, Elmendorf collected about $337,000 in sharing reimbursements from the Anchorage VA Outpatient Clinic. Of the total collected, about $202,000 (60 percent) was transferred to the Air Force's centrally managed military pay appropriation account. According to the administrator, the other $135,000 (40 percent) was credited to the facility, but its O&M budget was reduced by a like amount.

Elmendorf's administrator observed that, even though sharing reimbursements are not directly credited to the hospital, the hospital can potentially benefit indirectly from sharing activities. VA workload as well as military workload is counted and used to justify future military personnel allocations. However, the administrator stated that this factor in no way makes up for the lost military pay reimbursements and the reduction in operating funds. The administrator gave several reasons for this, including the following:

- The process used by Air Force higher headquarters to assign staff to Air Force hospitals is retrospective, not prospective. Workload is performed, and then it is hoped that staff will be assigned sometime in the future based on that workload. There is no quick payback to the hospital, as there would be if sharing reimbursements could be collected and then used right away for purchasing equipment, hiring new staff, etc.
- Even when increased VA workload results in additional staff authorizations, frequently the additional staff slots are not funded, and no new personnel are assigned to the hospitals.

In an April 1986 report, the Office of the VA Inspector General recommended that VA reduce its use of costly civilian providers in Alaska partly by expanding its sharing agreement with Elmendorf. VA's Chief Medical Director agreed that the sharing agreement with Elmendorf was inadequate, but stated that:

"One fallacy in indicating that a properly negotiated sharing agreement would encourage Elmendorf to handle more VA inpatients is (the VA Inspector General) report's implication that fees paid to the Air Force for services would be passed through to Elmendorf to offset the additional expenses they incur in care of these patients. A minimal amount of those fees actually are passed through to the medical center, therefore, the additional expenses become a disincentive to an expanded sharing agreement.

"This problem must be resolved at the highest levels of federal sharing agreement policy setting before sharing will become appealing to service providing organizations."

Tripler Army Medical Center

We estimated that at Tripler Army Medical Center, Hawaii, during fiscal years 1985 and 1986, VA reimbursed the Army about $11 million. Although a Public Law 97-174 sharing agreement between the Honolulu VA Outpatient Clinic and Tripler was in effect for about half of this period, none of the VA reimbursements went to Tripler. Instead, they all went to the Army Health Services Command. According to the chief of

the Accounting and Operations Branch at the Health Services Command, the command deposited about half of the reimbursements in the Army's centrally managed military pay appropriation account, while the O&M portion was deposited in a special fund used to help defray the cost of medical/dental services provided to the Army by VA, the Public Health Service, and other federal agencies.

The reimbursement procedures followed by VA and Tripler were in effect before the Public Law 97-174 sharing agreement, when Tripler provided care to VA under an interagency support agreement authorized by the Economy Act. According to Tripler's director of resource management, these reimbursement procedures were not altered when the sharing agreement went into effect in January 1985 because Tripler officials believed that local collection of reimbursements would not provide any financial advantage to the medical center.

Conclusions

Although Public Law 97-174 was intended to give VA and military hospitals a financial incentive to provide services to each other, only VA has adopted reimbursement procedures that provide such an incentive to local hospital managers. DOD's process for dealing with reimbursements received from VA under sharing agreements may enable military hospitals to benefit indirectly from past sharing efforts through eventual increases in future years' budgets and staffing levels, but it does not provide assurance to hospital managers that their hospitals will benefit directly from enhanced sharing with VA.

The willingness of many military hospitals to share their services with VA in the future will depend, in large part, on the extent to which DOD gives them incentives to do so. DOD could give military hospitals a stronger incentive to share if hospital managers were explicitly informed by headquarters personnel and budget officials of the military personnel staffing adjustments and the amounts of O&M obligational authority with which the hospitals have been provided to fund their anticipated reimbursable work under Public Law 97-174 sharing agreements.

Recommendations

To provide the incentive that Public Law 97-174 intended, we recommend that the Secretary of Defense direct the Assistant Secretary of Defense (Comptroller), in consultation with the service secretaries, to develop procedures to ensure that DOD hospital managers—at the time they are provided military medical personnel staffing authorizations

and O&M budgets—are explicitly informed of the amounts of resources being provided to handle anticipated reimbursable work under Public Law 97-174 sharing agreements.

DOD Comments and Our Evaluation

In our draft report sent to DOD, VA, and OMB for comment, we recommended that the Secretary of Defense direct the Assistant Secretary, in consultation with the service secretaries, to develop accounting and budgeting procedures that allow reimbursements under Public Law 97-174 sharing agreements, unlike interagency reimbursements under the statutory authorities, to be credited to local facilities that have entered into such agreements.

DOD did not concur with that recommendation. DOD officials said our recommendation was not consistent with federal budget concepts or the long-standing GAO position on the disposition of reimbursements received. DOD officials stated that crediting military pay reimbursements to local facilities would result in an improper augmentation of DOD O&M appropriations since health care facilities are not responsible for the pay of their military personnel. They also stated that it would not be feasible to dismantle the military departments' central military pay systems in order to adopt a unique reimbursement procedure for DOD health care facilities.

DOD also disagreed with our position regarding its current practice of deducting the O&M portion of VA reimbursements from a facility's budget. Officials said that basic budgetary concepts include providing a specified level of total obligational authority to fund the operations of an activity. These officials stated that total obligational authority includes budget authority and anticipated reimbursements. If the anticipated level of reimbursements is not attained, the activity must obtain more budget authority or curtail its operations. Increasing budget authority to those facilities that have ongoing sharing agreements with VA would provide more funding than necessary for them to accomplish their missions and, according to the DOD officials, is not warranted.

We do not agree that the recommendation in our draft report would necessarily have to result in the effects on DOD's military personnel staffing and budgetary processes that DOD officials implied it would. However, in view of DOD officials' description of the military hospital budgetary process in which anticipated sharing reimbursements are credited to a facility's obligational authority when the facilities' budgets are developed, we have revised our recommendation. Our revised recommendation is

directed toward explicitly informing military hospital managers of the extent to which their obligational authority has been affected by anticipated sharing reimbursements. We believe this information is needed so that hospital managers will know that Public Law 97-174 sharing agreements benefit their facilities and they will be encouraged to pursue sharing opportunities with VA.

Legislative Restriction on VA Treating DOD Dependents Needs to Be Removed

DOD dependents are not permitted to receive medical treatment in VA facilities under Public Law 97-174 sharing agreements. VA, which had previously supported the restriction, has proposed legislative action to remove it. In its proposal, VA stated that DOD dependents could be treated in its medical centers under sharing agreements on a space-available, referral basis without modifying its facilities, changing its primary mission, or adversely affecting its veteran beneficiaries. Allowing VA medical centers to treat DOD dependents on a space-available, referral basis would provide opportunities for greater sharing of health care resources and enhance the government's ability to reduce rising health care costs. In addition, referrals of DOD dependents to VA facilities would strengthen VA teaching and training programs. Public Law 97-174 would have to be revised to bring about this change.

The Congress Restricted DOD Dependent Care in VA Facilities

Whether DOD dependents should be eligible for care in VA facilities was debated extensively in the Congress before the enactment of Public Law 97-174. The final bill did not allow VA to provide medical care to DOD dependents under sharing agreements.

Under VA's interpretation of Public Law 97-174, VA medical facilities may provide only limited services to DOD dependents. In general, according to VA's general counsel, VA facilities may provide ancillary services (such as X-rays and laboratory tests) to DOD dependents, but except for emergency cases, not medical care (such as outpatient surgery or inpatient treatment).

DOD Dependent Issue Was Debated by the Congress

During the legislative process that culminated with the passage of Public Law 97-174, several issues arose that required compromises. One was whether DOD dependents should be allowed to be treated in VA medical centers under certain conditions. After the debate, the final version of the bill did not allow DOD dependents to be treated in VA facilities under agreements negotiated pursuant to Public Law 97-174. The sharing law placed no restrictions on the types of VA beneficiaries who could be treated in DOD facilities.

Arguments for and against treating DOD dependents in VA medical facilities were raised during the legislative debate. Proponents of allowing such treatment noted that many dependents were already receiving services in VA medical centers in many areas of the country on a space-available, referral basis. According to these advocates, VA physicians

had said that such sharing could be continued without any adverse impact on VA's primary beneficiaries.

On the other hand, opponents of allowing DOD dependents to be treated in VA medical centers said that VA facilities were not equipped to handle large numbers of children or women. VA's Chief Medical Director, who opposed treating DOD dependents, said that allowing VA to treat DOD dependents would indicate congressional intent to modify VA hospitals to care for nonveterans.

VA Determined Some Services to DOD Dependents Were Allowable

Public Law 97-174 states that an individual who is a primary beneficiary of the agency may be provided health care at a facility of the other agency that is a party to the sharing agreement. The law states that the term "primary beneficiary" means, with respect to DOD beneficiaries, a member or former member of the armed forces who is eligible for care under 10 U.S.C. 1074. In 1984, VA's Office of General Counsel stated that DOD dependents are not primary beneficiaries of DOD under this definition. Consequently, VA held the view that DOD dependents may not be furnished care or medical services in VA facilities under Public Law 97-174.

In a 1986 legal opinion, however, the VA general counsel qualified his 1984 position on the DOD dependent issue, holding that DOD dependents could obtain certain services at VA facilities. The general counsel noted that the sharing law grants broad authority for VA to provide services to DOD; the only limitation is on providing health care to DOD dependents or other nonprimary beneficiaries who are in a VA facility. The general counsel stated that one could draw a distinction between VA's providing care directly to a DOD dependent and providing ancillary services to a military facility in connection with its care of DOD dependents. For example, scheduling DOD dependents to undergo X-ray studies in a VA facility is permissible since this assists DOD in caring for its patients. However, the general counsel concluded that providing medical treatment (e.g., outpatient surgery) and inpatient services to DOD dependents in VA facilities was not authorized by the sharing law.

Legislation Introduced in the Congress to Remove the DOD Dependent Restriction

During 1986, two bills were introduced in the Congress—one in the Senate and one in the House—to remove the restriction on VA treating DOD dependents under VA/DOD sharing agreements. However, the 99th Congress took no action on either bill.

A bill—H.R. 1355—identical to the 1986 House bill was introduced in March 1987. Like the previous bill, this bill seeks to improve the efficiency and reduce the costs of VA and DOD hospitals by expanding the authority to share health care resources. H.R. 1355, in essence, extends VA/DOD sharing authority under Public Law 97-174 to any individual eligible to receive health care at either VA or DOD facilities. As a result, under a Public Law 97-174 sharing agreement, VA would be permitted to provide health care to any individual eligible for health care from DOD, including DOD dependents.

We endorse enactment of H.R. 1355. This legislation, permitting treatment of DOD dependents in VA medical facilities under Public Law 97-174 sharing agreements, would retain the qualification that such treatment be on a space-available, individual referral basis and that treatment of veteran beneficiaries may not be adversely affected.

VA Proposed Removing DOD Dependent Restriction

In an August 29, 1986, letter to the OMB Director, the Administrator of Veterans Affairs submitted VA's legislative program for the 100th Congress and included a proposal to provide VA health care to DOD dependents at VA facilities. The proposal stated, in part:

"This proposal would authorize the provision of VA health care to DOD dependents at VA facilities under VA/DOD sharing agreements. Currently, the law, at 38 U.S.C. 5011(d)(1), prohibits the provision to DOD dependents of VA health care in VA facilities under VA/DOD sharing agreements authorized by 38 U.S.C. 5011(c).

"The legislative history of this prohibition shows that it was enacted apparently because Congress believed VA did not have the resources to treat DOD dependents who are usually women and children and feared that dependents would take beds needed by veterans. The law, however, currently permits the provision of direct health care to DOD beneficiaries in VA facilities under a section 5011(c) sharing agreement only if the care does not adversely affect the range of services, quality of care, or the established priorities for care provided to eligible veterans (38 U.S.C. 5011(d)(3)). Thus, admission of dependents under the proposal would not displace veterans. In addition, the VA has recently increased its capacity to provide care for women because of the increasing number of female veterans. This prohibition, therefore, is no longer warranted.

"Enactment of this proposal would not result in additional costs to the VA. Instead, it would likely provide savings through more efficient use of resources."

VA's position in its proposal on the DOD dependent issue is consistent with the position we advocated in our 1978 report to the Congress recommending sharing legislation. We concluded in that report that restrictions on the types of beneficiaries agencies could treat in their facilities created an obstacle to effective interagency sharing and would limit the government's ability to curb rising health care costs.

Interviews with directors and other senior officials at VA medical centers show that allowing DOD dependents to use VA facilities on a space-available, individual referral basis would not adversely affect veterans' access to care. We identified several VA medical centers—such as Nashville, Tennessee, and Castle Point, New York—that routinely provided ancillary services (such as CT scans or consultations) to DOD dependents under sharing agreements. Officials at these centers told us the centers were also capable of providing medical treatment services (such as outpatient surgery) to DOD dependents in the same way they provided ancillary services: without altering their primary mission, eligibility priorities, or facilities. Furthermore, several officials stated that providing services to DOD dependents gave their centers a wider variety and mix of patients (including women and children) than would otherwise be possible, and therefore advanced the teaching and/or training missions of the centers as well as their ability to meet the needs of female veterans. Officials said referrals of DOD dependents for medical treatment services would further strengthen teaching or training missions.

VA's legislative proposal to remove the DOD dependent restriction was rejected by OMB. An OMB official told us in June 1987 that OMB believed that the VA medical care system was created to treat eligible veteran beneficiaries and that, except for emergencies, its role should continue to be limited to that purpose.

We do not agree with OMB's position. First, it is inconsistent with other sharing authorities. VA is now authorized to provide nonemergency care to persons who are not VA beneficiaries. Under 38 U.S.C. 5053, which allows VA to share specialized medical services, and 31 U.S.C 1535, the Economy Act, VA is authorized to provide medical services to persons who are not VA beneficiaries. Second, OMB's position, in our view, ignores a basic premise of Public Law 97-174 sharing agreements. Any sharing agreement to allow DOD dependents to be treated in VA medical facilities would be on the basis of (1) space being available in VA facilities and (2)

specific patient referrals agreed to by DOD and VA facility officials. Thus, a sharing agreement to allow treatment of DOD dependents would not affect the established priorities for treatment of VA beneficiaries.

Future Sharing Projects May Be Hampered by DOD Dependent Restriction

One major sharing project that was complicated by the limited authority in Public Law 97-174 for VA to treat DOD dependents occurred in Albuquerque, New Mexico. (See p. 14.)

According to the deputy director of VA's Emergency Management and Resource Sharing Service, the project was made more complicated because it will use three authorities to accomplish the objectives when only one—Public Law 97-174—should be required. In addition to Public Law 97-174 providing the basic authority for sharing agreements, VA's authority to share specialized medical services (38 U.S.C. 5053) and the Economy Act (31 U.S.C. 1535) must also be used to allow DOD dependents access to the Albuquerque VA medical care facilities. According to officials of VA's Emergency Management and Resource Sharing Service, this project could have been put together much more quickly and easily under one authority because (1) the VA specialized medical resources sharing authority (38 U.S.C. 5053) is a year-to-year agreement, whereas Public Law 97-174 sharing agreements can remain in effect longer than a year; (2) there would be no need for separate sharing agreements within the project; and (3) any sharing taking place under the Economy Act requires reimbursement based on total cost, which has proved to be a barrier to sharing agreements in the past.

The VA Resource Sharing Service officials told us that Albuquerque is a pilot project, which they hope will be a forerunner of more such projects to come. However, they believe that future projects may be hampered by having to use several authorities when only one, Public Law 97-174 with the dependent restriction removed, would be necessary. They also stated that another project, in the Las Vegas, Nevada, area, is not affected by the lack of authority for VA to treat DOD dependents. (See pp. 15.) In that project, VA will share an Air Force hospital, and DOD has no restrictions on treating any category of VA beneficiaries under Public Law 97-174 sharing agreements.

Conclusions

Public Law 97-174 does not permit VA to treat DOD dependents under sharing agreements; only primary beneficiaries of DOD may be treated. However, since enactment of Public Law 97-174, several bills have been introduced in the Congress to remove the dependent restriction, and VA

has proposed amending legislation allowing DOD dependents to be treated under VA/DOD sharing agreements. OMB, however, continues to oppose allowing treatment of DOD dependents in VA medical facilities on the basis that the VA medical care system was created to treat veterans only.

OMB's position is inconsistent with the fact that nonveterans are being treated in VA facilities under other federal legislation. We believe that all beneficiaries should be allowed to be treated under sharing agreements on a space-available, referral basis and that the DOD dependent restriction in Public Law 97-174 is unnecessary. Removing the restriction would help promote optimal VA/DOD sharing and savings to the government and should encourage future sharing projects.

Recommendation to the Congress

We recommend that the Congress enact legislation authorizing VA to accept all categories of DOD beneficiaries under a VA/DOD sharing agreement on a space-available, referral basis when care of VA's beneficiaries would not be adversely affected. Specifically, 38 U.S.C. 5011(d)(1) should be amended to remove the restriction on VA providing health care to DOD beneficiaries.

Agency Comments and Our Evaluation

DOD Comments

DOD concurred in our recommendations to amend the law to permit treatment of DOD dependents in VA medical facilities.

VA Comments

In commenting on a draft of this report, the Administrator of Veterans Affairs stated that a proposal to eliminate the prohibition against treatment of DOD dependents in VA medical facilities was submitted to OMB for review but was not an official agency position. He said that the proposal was not intended for release outside the executive branch. As noted on page 37, the VA proposal on the DOD dependent issue was submitted to OMB in a letter signed by the Administrator as part of a proposed legislative package for the 100th Congress.

OMB Comments

In commenting on a draft of this report, OMB's associate director for human resources, veterans and labor stated that OMB opposes allowing DOD dependents to be treated in VA medical facilities. He said that dedicating VA resources to treat DOD dependents would entail an increase in VA operating costs and that this kind of expansion in direct federal health care is not desirable when other sources of care, including care by the private sector through CHAMPUS, are available.

OMB's position is contrary to a fundamental premise on which Public Law 97-174 was based—that increased interagency sharing opportunities would enhance the government's ability to provide care to federal beneficiaries in the most cost-effective way. The purpose of the recommended change to Public Law 97-174 is to provide additional opportunities for this to occur. If, as OMB implies, having some care provided to DOD beneficiaries by the private sector constitutes a more cost-effective alternative for military hospital commanders to pursue, they should pursue this alternative. If, on the other hand, the government would benefit from VA's providing some care to DOD beneficiaries, the commanders, along with the VA hospital administrators, should pursue this alternative.

OMB's assertion that our draft report suggests that VA resources be "dedicated" to treating DOD dependents is not correct. As discussed in our report, VA's treatment of DOD dependents in VA medical facilities would, under our recommended change to Public Law 97-174, occur only on a space-available, referral basis. Therefore, VA resources would not be dedicated to treatment of DOD dependents, and we do not foresee any significant unreimbursed cost increases to VA. Nor do we forsee that an enhanced interagency sharing program would result, as OMB asserts, in an expanded direct federal health care system.

Restrictions on CHAMPUS Funds Preclude Use of VA Medical Resources

During our review, funds for the two components of DOD's health care system were appropriated and administered separately. The direct care system was funded and operated by the respective military services, and hospital commanders were responsible to their respective services for operating their facilities within the established funding limitations. CHAMPUS, on the other hand, was centrally administered by the Office of the Assistant Secretary of Defense (Health Affairs), and neither the services nor hospitals were held accountable for CHAMPUS costs.

Beginning in fiscal year 1988, CHAMPUS funds will be included in the military services' budgets. Although CHAMPUS funds are now included in the services' budgets, restrictions imposed by the Congress on use of the funds may prevent the potential benefits associated with treatment of DOD dependents in VA medical facilities discussed in chapter 5 from being fully realized.

DOD Regulation Blocks VA Capture of CHAMPUS Care

Although a portion of CHAMPUS care could potentially be provided by VA medical centers more cost effectively, a DOD regulation prohibits CHAMPUS funds from being used to reimburse federal medical care providers. This limitation on use of CHAMPUS funds has created a disincentive for military medical officials to refer military beneficiaries to VA medical centers.

Potential for VA to Provide Care to CHAMPUS Beneficiaries

A November 1985 study prepared by Vector Research, Incorporated (a DOD consultant), identified CHAMPUS workloads that could potentially be absorbed by VA medical centers. The study found that during fiscal year 1984, 11 percent of the $963 million spent by DOD for CHAMPUS inpatient care was for obstetric services, which VA medical centers do not provide. The remaining 89 percent of the DOD expenditures for CHAMPUS inpatient care were for medical, surgical, and psychiatric care—three types of care offered by most VA medical centers. The study also noted that DOD expenditures for CHAMPUS hospital services provided to adult males--the group that would be most easily assimilated into the VA system—totaled over $132 million.

Commanders and other officials at military hospitals told us that budget constraints severely limited the number and types of patients they could refer to VA medical centers. They stated that their hospitals' insufficient funding for non-active duty care, along with their inability to use CHAMPUS funds to finance such care, curtailed their ability to use VA medical centers.

At the Great Lakes Naval Hospital, for example, physician losses and other staffing problems during fiscal year 1986 led to cutbacks in several hospital departments. As a result, the hospital discontinued providing care to many DOD dependents and retirees. The director of the North Chicago VA Medical Center—located about a mile from Great Lakes—said many of the discontinued services were available at his facility. He believed the medical center could treat many additional DOD beneficiaries at a much lower cost than civilian hospitals if Great Lakes could reimburse North Chicago. According to Great Lakes' head of patient administration, the naval hospital had insufficient funding for DOD beneficiary care, and referrals of beneficiaries to North Chicago for services other than diagnostic tests or consultations were generally not feasible. Consequently, the hospital had no alternative to discontinuing care for many beneficiaries. The official said that increased use of CHAMPUS—unlike referrals to VA facilities—had no impact on Great Lakes' operating funds since CHAMPUS funds were not included in its budget. Instead, CHAMPUS funds were controlled by the Office of the Assistant Secretary of Defense (Health Affairs).

CHAMPUS Cannot Reimburse VA Medical Facilities

DOD could encourage military hospitals to refer additional beneficiaries to VA medical centers if CHAMPUS funds could be used to reimburse the VA centers. However, DOD Regulation 6010.8 (chapter 4, section G) generally excludes services furnished by the federal government (including VA) from being paid for by CHAMPUS funds. The chief, Resource Management Division, Office of CHAMPUS, told us he believed the Congress intended CHAMPUS to pay only for care furnished by civilian providers.

Sharing Activities in Tennessee-Kentucky Area Disrupted

DOD budget restrictions and CHAMPUS payment procedures can indirectly disrupt certain types of sharing activities and probably increase CHAMPUS costs. This was illustrated by the problems encountered by Blanchfield Army Community Hospital, Fort Campbell, Kentucky.

Blanchfield's successful sharing relationship with the Nashville VA Medical Center was disrupted in 1986, when the Army hospital nearly ran out of supplemental care funds.[1] Blanchfield relied primarily on supplemental care funds to reimburse Nashville for CT scans and other diagnostic tests and, when confronted with a shortage of funds, decided to

[1] Funds generally used by military hospitals to augment medical treatment provided by the hospitals' physicians. The funds are used primarily for diagnostic tests, consultations, medical supplies, oxygen, and civilian ambulance services.

sharply curtail referrals of non-active duty patients to the VA medical center. Blanchfield later discontinued medical care for many non-active duty patients and advised them to use CHAMPUS instead of the VA medical center to obtain tests. Non-active duty referrals to VA declined from 47 in October 1985 to 4 in September 1986, a decrease of over 90 percent.

Because Blanchfield maintains limited records on discontinuances of patient care, we were unable to determine how many non-active duty patients ultimately sought care from CHAMPUS providers when they could not obtain diagnostic tests or consultations through the supplemental care program. However, Blanchfield officials we interviewed generally believed that significant numbers of non-active duty patients who were no longer receiving care from the military direct care system as a result of the supplemental care fund restrictions were turning to CHAMPUS providers for medical care.

In October 1986 Blanchfield's chief of surgery told us that because of the lack of supplemental care funds to pay for CT scans and nuclear medicine tests, surgeons at the hospital were discontinuing care for 25 to 50 patients each month. He stated that virtually all such patients were obtaining CT scans or nuclear medicine tests, as well as any surgery or other follow-up treatment needed, from CHAMPUS providers. The official noted that Blanchfield has the necessary personnel and facilities to provide medical treatment for most of the patients, but the lack of supplemental care funds to pay for diagnostic tests and consultations interfered with the continuity of care, and discouraged patients from continuing to use Blanchfield's facilities.

Recently Enacted Legislation Does Not Expressly Authorize CHAMPUS Funds to Reimburse VA

To make the armed services accountable for CHAMPUS expenditures, the National Defense Authorization Act for Fiscal Year 1987 (Public Law 99-661, Nov. 14, 1986) gave each military service, beginning in fiscal year 1988, control over most of the CHAMPUS funds. According to the House Committee on Armed Services' report on the bill that became the Defense Authorization Act (H.R. Rep. No. 99-718, July 25, 1986), this action will enable military services hospitals to use CHAMPUS funds to expand services in the DOD direct care system or contract with civilian providers. The act did not, however, specifically give the services authority to use the funds to purchase care from VA medical centers.

The House report further stated that with the change in CHAMPUS funding, together with appropriations for the direct care system, the armed

services would be responsible for providing medical care to their beneficiary population through the most economical means available. According to the report, rather than referring a patient to CHAMPUS for care not available in a military hospital, it might prove less costly to use part of the CHAMPUS funds to contract for additional staff in the military hospital or contract with civilian providers in the local community for certain services unavailable in the military facility due to staffing or other constraints. However, neither the act's legislative history nor the act itself specifically addressed the use of CHAMPUS funds to purchase care from VA medical centers.

Additional restrictions on use of CHAMPUS funds were discussed during congressional action on DOD appropriations for fiscal year 1988. According to the Committee on Appropriations' report on the Department of Defense Appropriation Bill, 1988 (H. Rep. No. 100-410, Oct. 28, 1987) the military services were to use CHAMPUS funds only for (1) payment of claims submitted to them by OCHAMPUS, (2) funding of CHAMPUS-approved demonstration projects, and (3) costs associated with the CHAMPUS Reform Initiative—a program to provide care to CHAMPUS beneficiaries under a fixed price contract. The Conference Committee for the Omnibus Budget Reconciliation Act of 1987 concurred.

Conclusions

Current restrictions imposed by both the DOD regulation and later congressional action on the use of CHAMPUS funds create a disincentive for military hospital managers to use nearby VA medical facilities. Such restrictions prevent DOD hospitals from using VA medical centers that could potentially assist them in providing care to many DOD beneficiaries at a lower cost than civilian providers.

Recently enacted legislation should be amended to permit the use of CHAMPUS funds to reimburse VA medical centers for treatment of CHAMPUS beneficiaries under Public Law 97-174 sharing agreements.

Recommendation to the Congress

We recommend that the Congress amend the National Defense Authorization Act of Fiscal Year 1987 to specifically authorize the military services to use CHAMPUS funds to purchase care from VA medical centers, when it is cost-effective to do so.

Agency Comments and Our Evaluation

DOD Comments

DOD concurred in our recommendation.

OMB Comments

In commenting on our draft report, OMB stated that it opposed permitting CHAMPUS funds to be used to reimburse VA for care provided to DOD beneficiaries. OMB based its view on the same arguments that it used in opposing treatment of DOD dependents in VA medical centers. (See p. 41.)

VA and DOD Medical Facilities Visited by GAO

Anchorage, Alaska, area
Anchorage VA Outpatient Clinic
USAF Regional Hospital, Elmendorf Air Force Base

Castle Point, Montrose, and West Point, New York, areas
Castle Point VA Medical Center
Franklin Delano Roosevelt VA Hospital
Keller Army Community Hospital

Charleston, South Carolina, area
Charleston VA Medical Center
Naval Hospital Charleston

Honolulu, Hawaii, area
Honolulu VA Outpatient Clinic
Tripler Army Medical Center

Long Beach, California, area
Long Beach VA Medical Center
Naval Hospital Long Beach

Nashville, Tennessee/Hopkinsville, Kentucky, areas
Nashville VA Medical Center
Colonel Florence A. Blanchfield Army Community Hospital

North Chicago, Illinois, area
North Chicago VA Medical Center
Naval Hospital Great Lakes

St. Louis, Missouri/Mascoutah, Illinois, areas
St. Louis VA Medical Center
USAF Medical Center, Scott Air Force Base

Salt Lake City, Utah, area
Salt Lake City VA Medical Center
USAF Hospital, Hill Air Force Base

San Diego, California, area
San Diego VA Medical Center
Naval Hospital San Diego

San Francisco, California, area
San Francisco VA Medical Center
Letterman Army Medical Center

Syracuse and Rome, New York, areas
Syracuse VA Medical Center
USAF Hospital, Griffiss Air Force Base

Comments From the Veterans Administration

Office of the
Administrator
of Veterans Affairs

Washington DC 20420

Veterans
Administration

NOV 24 1987

Mr. Richard L. Fogel
Assistant Comptroller General
U.S. General Accounting Office
Washington, DC 20548

Dear Mr. Fogel:

This responds to your request for comments on the September 29, 1987, draft report VA/DOD HEALTH CARE: Further Opportunities to Increase the Sharing of Medical Resources. The General Accounting Office (GAO) states that the Veterans Administration (VA) and the Department of Defense (DOD) have made significant progress in developing sharing agreements, but several obstacles continue to impede optimum sharing of medical resources. One of these obstacles is identified as the misunderstanding by officials at several VA and DOD hospitals that reimbursement rates for services performed must reflect actual costs whereas Public Law 97-174, the VA/DOD Health Resources Sharing and Emergency Operations Act, permits establishing reimbursement rates below actual costs. (GAO defines "actual" or "full" costs as those that are not only directly associated with the service being the shared, but also include costs not directly attributable to the shared service, such as fixed and administrative, or overhead, costs.)

GAO recommended that the Secretary of Defense and I enhance DOD and VA medical sharing opportunities by notifying each of our medical center directors, hospital commanders, and audit and inspection organizations that, under the VA/DOD Health Resources Sharing Guidelines, reimbursement rates may be locally negotiated at less than actual cost.

The VA concurs in this recommendation. The Department of Medicine and Surgery's "Management and Operational Activities" manual (M-1, Part I), in Chapter 1, "Medical Administrative Activities," will include a new section on VA/DOD sharing. This section will clarify reimbursement methodology and will state that reimbursement rates are locally negotiable and may be negotiated at less than actual costs. We anticipate sending this new section to our field facilities in the early part of 1988. The VA Office of Inspector General routinely considers sharing agreements when preparing to audit medical centers and reviews all governing regulations and thus will be aware of the reimbursement methodology to be described in the new manual section.

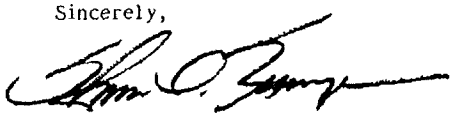
2.

Mr. Richard L. Fogel

Now on pp 37-38

The draft report contains a discussion of the prohibition for VA to provide health care to DOD dependents under VA/DOD sharing agreements. GAO states that VA has changed its position with respect to this prohibition and has called for legislation to eliminate it. (See pages 50, 54-56, and 60.) This is incorrect. VA's draft reports on legislation introduced in the 99th Congress were under review by the Office of Management and Budget (OMB) when the Congress adjourned in October 1986. Although those draft reports favored eliminating the prohibition, they were never presented to me for signature. Thus, they do not represent an official VA position. The proposal prepared for the 100th Congress was submitted to OMB for review but was not an official Agency position. It was a proposal, not intended for release outside the Executive Branch. Therefore, we suggest deleting from the report the statements that VA has officially taken a position in favor of legislation to eliminate the prohibition.

Sincerely,



THOMAS K. TURNAGE
Administrator

Comments From the Office of Management and Budget

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C 20503

NOV

Mr. William J. Anderson
Assistant Comptroller General
U. S. General Accounting Office
Washington, D. C. 20548

Dear Mr. Anderson:

On September 29, 1987, the Office of Management and Budget (OMB) received for comment a draft General Accounting Office (GAO) report entitled VA/DOD Health Care: Further Opportunities to Increase the Sharing of Medical Resources. This letter provides OMB comments on the draft report.

The draft report recommends that:

-- Public Law 97-174 be amended to remove the restriction on the Veterans Administration (VA) providing health care to Department of Defense (DOD) beneficiaries under VA/DOD sharing agreements;

-- the National Defense Authorization Act of 1987 be amended to specifically authorize the armed services to use CHAMPUS funds to purchase care from VA medical centers;

-- the Secretary of Defense and the Administrator of Veterans' Affairs "clear up confusion" about reimbursement rate setting; and,

-- the Secretary of Defense revise DOD's reimbursement mechanism to provide military hospitals with an incentive "to share as the Congress intended."

OMB continues to believe in the wisdom of maintaining the restriction in Public Law 97-174 on VA providing health care to DOD beneficiaries. While scattered examples can be found, as GAO has done, of "excess capacity" in the VA system that might be used for the treatment of additional patients, we believe that dedicating VA resources to the treatment of DOD dependents would entail an increase in VA operating costs for more and different kinds of staff, more supplies, more equipment, and different kinds of facilities. This kind of an expansion in direct Federal health care is not desirable, from our point of view, when other sources of care, including care furnished by the private sector through the CHAMPUS program, are available.

Consistent with our view on maintaining the existing restriction in Public Law 97-174, we also believe that the National Defense Authorization Act of 1987 should not be amended to authorize the armed services to use CHAMPUS funds to purchase care from VA medical centers.

Furthermore, we believe that the Secretary of Defense and the Administrator of Veterans' Affairs should move cautiously in pricing the services they provide to each other below full costs, as advocated by GAO. The problem of proposing solutions without adequate investigation is illustrated by an example used in the draft report involving a VA laundry facility with excess capacity. In this example, the draft report indicates that "little or no effect on plant operating expenses" would take place if workload was increased by one-sixth. Since there would be obvious effects on staffing, supplies, and utilities from such an increase, it is difficult to understand how this statement can be accurate.

We are concerned that adoption of the practice of setting reimbursement rates below the actual cost of care will understate the cost of providing care to DOD beneficiaries in the DOD budget. This practice will result in the Veterans Administration providing a direct subsidy to the DOD medical system. Further, the practice of below cost reimbursement to VA may lead the DOD to neglect other uses of its resources, such as civilian contracting or incremental additions to its own program, which may have actual costs lower than the VA. This is particularly true in the case of CHAMPUS-funded care where, due to beneficiary cost-sharing requirements, the government pays for only 75 to 80 percent of total costs.

A final point is that we believe the VA medical care system should be maintained for veterans and should not have its mission diluted by taking on responsibilities for the care and treatment of non-veterans as a part of routine business.

Thank you for the opportunity to comment on the draft report.

Sincerely yours,

Jay Plager
Associate Director for Human Resources, Veterans and Labor

* U.S. G.P.O. 1988-201-749:60267