VA/DOD HEALTH CARE SHARING

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

ONE HUNDRED SIXTH CONGRESS

SECOND SESSION

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VA/DOD HEALTH CARE SHARING

WEDNESDAY, MAY 17, 2000

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The subcommittee met, pursuant to call, at 10:30 a.m., in room 334, Cannon House Office Building, Hon. Cliff Stearns (chairman of the subcommittee) presiding.

Present: Representatives Stearns, Gutierrez, Peterson, Snyder, Rodriguez, and Shows.

OPENING STATEMENT OF CHAIRMAN STEARNS

Mr. STEARNS. Good morning. The Subcommittee on Health will come together, and I appreciate everybody's patience as we were tied up in Republican conference and had some serious votes.

In 1982, Congress enacted legislation authored by Senator Charles Percy of Illinois to foster greater sharing of health resources between the VA and the Department of Defense. Prior to that, VA and DOD medical facilities, sometimes adjacent to each other, operated independently despite opportunities to save money by obtaining needed services from one another. The 1982 law aimed to remove legal barriers and also provide incentives for military commanders and VA facility directors to engage in sharing.

This sharing law, Public Law 97–174, gave local hospital administrators maximum latitude to work out sharing arrangements and limited headquarters from stifling local decisionmaking. The law provided for flexibility and reimbursement rates and required the facilities to retain funds received under sharing agreements.

To ensure that sharing would remain a key mission, Congress required the VA's chief medical director and DOD's Assistant Secretary for Health Affairs to make health care resources sharing an ongoing and joint responsibility. That responsibility is to be carried out through a high-level VA/DOD committee which is to review policies and practices related to sharing, identify further opportunities for sharing, and recommend changes in policies and practices to promote increased sharing.

The sharing law has seen significant gains over the years, though with joint sharing revenues totaling 2/10 of 1 percent of the combined VA/DOD health care budget, this program has clearly not realized its full potential. Even more troubling, my colleagues, until just days ago, there were indications that past progress might even be further eroding. On the one hand, the two departments' annual sharing report to Congress suggests that as of January 2000 shar-

ing is a robust program with virtually all VA and DOD facilities involved; yet only 8 months before, VA's Under Secretary for Health, Dr. Ken Kizer, wrote to his counterpart at DOD expressing grave concern over policy changes at DOD and this is what Dr. Kizer said:

'the heart of VA/DOD health resources sharing for the past 15 years has been sharing of resources between VA medical centers and DOD medical facilities. These agreements are serving both of us well and have saved our respective Departments many millions of dollars in health care services while providing high-quality health care services to our beneficiaries. I am concerned that many of these agreements may now be in jeopardy as an unintended result of DOD Tricare implementation.".

To the best of my understanding, the issues Dr. Kizer raised did not get top-level attention at DOD until the days or weeks before our hearing. Equally troubling is that despite a requirement for annual reporting to Congress on VA/DOD sharing, neither department reported the existence of any problems to this committee. But for the fact that this committee requested the GAO to conduct a review of VA/DOD sharing last year, it is likely that Congress would still be in the dark. In reading today's testimony, I am now concerned that recommendations made by the GAO may have the unintended effect of delaying indefinitely any new sharing initiatives regardless of their merit.

It was noted in a hearing on VA/DOD sharing in 1995 that much of the progress that has been made in expanding the VA and Department of Defense sharing can be attributed to the efforts of this committee. I am confident that this will not be the last hearing on this subject, but of course I think it is a very timely one. Certainly the VA and DOD health care systems have changed markedly since the sharing program was launched. I do not believe that those changes suggest that the interdepartmental coordination should be relaxed or abandoned. I hope that we can learn today how that relationship can be strengthened.

I believe this hearing represents an opportunity to get a good picture of the status of the sharing program and to understand its successes and the challenges it still faces. Perhaps more important, though, I hope we can advance current thinking on how we can advance the overlapping health care missions of these two Departments with an eye toward promoting the interest of their beneficiaries and the taxpayers.

And in that regard, I am particularly pleased and appreciate that Tony Principi, the chairman of the Congressional Commission on Servicemembers and Veterans Transition Assistance has taken time to discuss that subject with us. We are fortunate to have had Tony head this important body. Under his leadership, the Commission brought a refreshing strategic vision to the subject and provided a set of far-reaching recommendations. They merit our attention, inquiry, and discussion.

In closing, let me welcome all of our distinguished witnesses.

And at this point, Mr. Peterson?

OPENING STATEMENT OF HON. COLLIN C. PETERSON

Mr. PETERSON. Thank you, Mr. Chairman. I don't really have a prepared statement, but I think that you are calling into question some important items that we need to take a look at and I appreciate your calling this hearing.

I just wanted to say that we had a couple of members that were here at the appointed time, Mr. Gutierrez and Mr. Snyder, who I would hope that we could count them as present for the record.

Mr. STEARNS. Without objection, so ordered.

Mr. PETERSON. I have another meeting that I have taking place at the present time, too. But I think this is an important question. We are not getting the kind of health care out there to either the veterans community or the DOD community. I keep hearing all of the time up in my country, you know, we have to drive long distances, and the kind of coverage that they want is not there. If we can make this whole situation work better, it seems to me that it would make our resources go further and make a better situation for our people. So I hope that this hearing can get some answers to some questions and move the process along in a positive manner. I appreciate your calling the hearing.

Mr. STEARNS. The gentleman from Texas, I thank you.

With that, I call Anthony J. Principi, Chairman, Congressional Commission on Servicemembers and Veterans Transition Assistance, and Stephen P. Backhus, Director of Veterans' Affairs and Military Health Care Issues at the GAO. Thank you, gentlemen for your patience.

STATEMENTS OF ANTHONY J. PRINCIPI, CHAIRMAN, CONGRESSIONAL COMMISSION ON SERVICEMEMBERS AND VETERANS TRANSITION ASSISTANCE; AND STEPHEN P. BACKHUS, DIRECTOR, VETERANS' AFFAIRS AND MILITARY HEALTH CARE ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, GENERAL ACCOUNTING OFFICE

STATEMENT OF ANTHONY J. PRINCIPI

Mr. PRINCIPI. Thank you. It is certainly a privilege to appear before you to testify on the health care findings and recommendations of the Commission on Servicemembers and Veterans Transition Assistance.

You have likely heard the saying there is nothing constant in the world except for change, and many things have changed over the years gone by and many more will change in the years to come. Change is one reason the Congress created our Commission. Many of the benefits and services provided to the men and women now leaving the Armed Forces and the organizational structures designed to meet them are rooted in the closing days of World War II, more than half a century ago.

Our Commission looked at how the country has changed in the military, in the civilian world, and in the servicemembers who make the transition from one to another. We found that access to high-quality health care is of critical importance to active duty servicemembers and veterans. The vast majority we spoke to during our commission's life indicated that health care is one of the most important benefits they receive from their military service.

Certainly based upon those discussions and our visits to military and VA hospitals, every commissioner came away with a positive impression about the quality of care provided to servicemembers, veterans, their families and retirees, and consider both systems to be unique and irreplaceable national resources critical to our Nation and its citizens.

At the same time, however, the commissioners found that the changing health care practices in our country, an evolving patient population, infrastructure built for another era, and increasing health care costs in a time of budgetary pressure will challenge the ability of the two systems, as currently structured, to meet the health care needs of their beneficiaries in this new century.

We found a true partnership between the VA and DOD health care systems offers the best hope for continued access to a continuum of high-quality care for the millions of beneficiaries of both Departments. A partnership would allow them to better serve their beneficiaries by making their combined resources accessible to all beneficiaries and allowing the Departments to realize efficiencies from more effective utilization of their limited resources.

The Commission recognizes the significant efforts that have been made to establish sharing agreements, drawing on the strengths of each departments but, considered in the context of the total beneficiary population and the combined budgets of both Departments, sharing has been incremental and marginal at best. We believe there are several reasons for this: differing administrative budgetary and personnel system; each uniformed service's desire to have its own specific providers; national traditions; differing catchment areas for DOD and VA facilities; and differing eligibility rules and priorities for beneficiaries.

These institutional and cultural barriers to increased cooperation and sharing are part of the reason the Departments project only $62 million of their $33 billion combined budgets will be transferred between Departments as a result of the sharing agreements. That figure may have changed but it is the figure we had at the time of our Commission.

The commissioners believe the Departments can do better, indeed must do better if the systems are to remain strong and viable well into this century. Difficult decisions will have to be made within the Departments and Congress to lower the barriers that impede the creation of a true partnership between DOD and VA. Failure to act will be paid by increasing numbers of beneficiaries who will be forced to turn elsewhere for their health care.

The Commission has drafted a blueprint that, if adopted, will create the framework for that partnership, a partnership that would maximize the return on the human and physical resources of DOD and VA and increase the number of beneficiaries they treat.

It is impossible to cover, in any detail, the many Commission recommendations on this subject, but I would just highlight a few. We believe using the combined purchasing power of both Departments for the procurement of VA/DOD pharmaceuticals, medical surgical supplies and equipment, and requiring the establishment of a joint formulary and universal product numbers will yield significant savings, close to $400 million a year. The DOD Inspector General re-

port recommended DOD use VA contracts and administration for such purchasing.

DOD and VA information technology and cost accounting systems should come closer together and we should restructure the budget appropriations and VA/DOD policy processes, so that indeed the budgets of both Departments will be considered together in the future.

Servicemembers and veterans will be the beneficiaries of these recommendations if the Departments and the Congress accept the challenges offered by the changing times and the health care recommendations formulated by the Commission in response to them. Thank you very much.

[The prepared statement of Mr. Principi appears on p. 27.]

Mr. STEARNS. Thank you. Mr. Backhus.

STATEMENT OF STEPHEN P. BACKHUS

Mr. BACKHUS. Good morning, Mr. Chairman and members of the subcommittee. I am pleased to be here to discuss VA/DOD sharing of health care resources. My remarks are based on a report that we are issuing today which describes the benefits and the extent of sharing, and analyzes the barriers and the challenges that VA and DOD face in their efforts to collaborate on cost-effective uses of Federal health care resources.

Our work identified a number of benefits that have resulted from sharing, including enhanced staff proficiency, fuller utilization of staff and equipment, and cost savings. Since the first sharing law was enacted in May 1982, the program has grown considerably to now over 400 active agreements and 8 joint ventures involving 150 facilities and almost 500,000 episodes of care, totaling near $50 million in services provided annually.

For the most part, sharing activity is concentrated in relatively few locations. For example, 75 percent of all inpatient care is provided at 12 facilities, outpatient care at 15 facilities and ancillary services at 12. Similarly, 75 percent of the revenue generated from sharing comes from just 30 facilities. While there have been many benefits to sharing, it seems the program is currently in turmoil. By that I mean there are several barriers and challenges that VA and DOD need to address, some of which are long-standing and which we have reported on before. Also, changes in VA and DOD health care systems such as the implementation of managed care, various efficiency and right sizing initiatives that have reduced excess capacity and projected demographic changes in patient populations will continue to affect the scope and magnitude of sharing opportunities.

The first barrier I would like to address concerns reimbursement policy and rates. Some VA and DOD hospitals still set reimbursements rates at total costs rather than incremental costs, making their services less attractive and, as a result, limiting collaboration. Each agency needs to reiterate its policies so that local sharing partners become aware of the flexibility they have.

Second, VA and DOD budgeting and resource allocation processes inhibit sharing because each agency budgets and allocates resources for its own beneficiaries only. Being able to acquire or increase resources that exceed the needs of a particular facility's pri-

mary beneficiaries may better serve the combined needs of both agencies.

Third, about 25 percent of the facilities reported to us that they are frustrated with the time it takes to receive approval, particularly from DOD headquarters, to enter into an agreement. Some indicated that such experiences have discouraged them from seeking potential sharing arrangements.

The fourth and most significant concern to a number of VA and DOD officials, including each of the Surgeons General, is Tricare. In response to a DOD legal opinion stating that local sharing agreements for direct medical care constitute competing networks with Tricare contractors, DOD issued a policy memorandum in May 1999 that many feel may nullify sharing agreements. According to the legal opinion, referring a DOD beneficiary to a VA sharing partner violates the Tricare contract. The policy in effect called into question 80 percent of local sharing agreements.

Exacerbating the situation, DOD also issued a policy transferring payment responsibility to its Tricare contractors. VA officials assert that since this policy went into effect, VA sharing partners have been paid late, not enough, or not at all.

DOD and its contractors acknowledge some payment problems, but contend that VA's billing system is antiquated and its records are in disarray and, thus, a significant source of the problem. These payment disputes in our view are the result of VA and Tricare contractors' different billing processes and the lack of clear guidance from DOD on what is required of its contractors and VA in order to achieve timely and accurate claims payment. We have learned in the past week that VA and DOD have taken certain steps to begin to address some of these concerns. However, we have not yet been provided the opportunity to review these steps to determine whether they are adequate remedies.

In conclusion, Mr. Chairman, we believe VA and DOD should aggressively seek ways to share resources where it is advantageous to the Federal Government. Notwithstanding the recent steps to address certain barriers, VA and DOD differ in their respective approaches to make the most cost-effective use of health care resources. This in turn has led to disagreements, misunderstandings, questions and challenges about each other's views towards sharing and their commitment to the program.

Therefore, we have recommended that the Secretaries of VA and DOD renew efforts to jointly assess how best to achieve the goals of health resource sharing and address the barriers. Specifically, we recommend that VA and DOD establish procedures to accommodate each other's budgeting functions as well as facilitate timely billing, reimbursement and agreement approval processes. We also recommended that DOD review and clarify its policy on the extent to which direct medical sharing is permitted with VA.

I am very encouraged by the recent actions to begin implementing our recommendations. Mr. Chairman, this concludes my statement. I will be happy to respond to any questions you have.

[The prepared statement of Mr. Backhus appears on p. 29.]

Mr. STEARNS. I thank both of you.

The original intent that Senator Percy had in 1982 was to foster greater sharing between the veterans hospitals and the military

hospitals, so to speak, to include sharing staff, space, purchases and equipment and so forth. This has rolled along all of these years and now the question is, after the GAO looked at it, whether it is effective and perhaps we even have to look at the question whether it is necessary.

I personally would like to try to find some way to quantify this so we can measure if there is some savings or impact rather than speaking in generalities.

Mr. Principi, your proposal calls for moving VA and DOD towards a new partnership. However, GAO calls for analysis by the two Departments to determine whether we should be rethinking the future of sharing.

So I would like in counterpoint, Mr. Backhus, you to comment on your idea first about the audit saying maybe we should rethink the future of sharing. Are you saying that we should not do it? How do you think that it should be done differently? I guess the real question is can you quantify this? Is there any way to say that are cost savings or improved access for the military people and veterans by quantifying this?

Mr. BACKHUS. There is no information that allows anybody to quantify what the full potential may be.

Mr. STEARNS. Have you seen written documents between the military and veterans on—any written documents that they have signed jointly?

Mr. BACKHUS. Yes, I have seen sharing agreements and our staff has analyzed a number of them and seen analysis within the sharing agreements that attempt to make a business case for those particular sharing agreements that are in effect. So for existing sharing agreements, there is documentation that gets to that topic.

Mr. STEARNS. Okay.

Mr. BACKHUS. However, there are a number of questions that one can ask about those agreements in terms of whether they are the most effective means of obtaining resources. In not every case is the DOD/VA partnership a win/win situation. There are opportunities in some cases to buy or obtain that care cheaper from, for example, the private sector.

So it is not necessarily always going to be to the advantage of the Federal Government for the two agencies to share resources, and that is where we see the need to rethink removable sharing strategies. The DOD, for example, has a different business model than the VA for purchasing care. They want to use the private sector to the extent that it is cost effective and provides good quality. In that respect, they see the VA as being one of those potential sources of care, but not always. And conceptually that seems sound.

There is a need to determine the best business case as well as other qualitative reasons for engaging the two agencies and that is the kind of analysis that we think needs to be made in a more systematic manner and that is why it is hard to quantify.

Mr. STEARNS. Are there any kind of incentives that you could put in place that would make a cost-effective arrangement?

Mr. BACKHUS. I think at the present time we see a lot of disincentives at the local level. Yes, there are incentives that can be in place.

Mr. STEARNS. Right now you see disincentives?

Mr. BACKHUS. Yes.

Mr. STEARNS. Mr. Principi.

Mr. PRINCIPI. Mr. Chairman, we went beyond sharing to talk in terms of a real partnership between the two agencies, a partnership wherein they jointly procure pharmaceuticals and medical supplies, not just share, recognizing that there are significant differences in missions between DOD and VA health care and that military medical readiness and taking care of our troops overseas and in times of conflicts has to remain the highest priority. But notwithstanding the differences in missions, there are great similarities, and we just believe that not consolidating the two Departments, but rather creating this partnership where budgets are considered jointly at OMB and on the Hill, perhaps the establishment of a joint policy staff to address some of the fundamental questions that exist, we believe the beneficiaries ultimately will benefit from such a partnership.

Mr. STEARNS. Do you think we should set up maybe a time line and, as a result of this hearing, come back with a time line, for example, for pharmaceutical drugs?

Mr. PRINCIPI. I certainly believe the Congress should do so. I think every year we wait—we leave money on the table that can be used to provide expanded care to beneficiaries. I am troubled that servicemembers, who in my opinion were guaranteed lifetime health care if they remained on active duty when they retired and reached the age of 65, are no longer eligible for DOD coverage. I think the fact that we have pretty reliable estimates that we are leaving anywhere from $300 million to $400 million on the table, moneys which can be used to provide care for military retirees 65 and older, is a real tragedy. There should be some time lines and we should break down some of these barriers that for too long have existed.

Mr. STEARNS. Mr. Backhus, do you believe that we should put in place some timelines for jointly assessing sharing and setting out how best to achieve those goals?

Mr. BACKHUS. Clearly. The last year has not been a good year for VA/DOD sharing and there has been a lot of struggle and disagreement between these two agencies. While the last week has been promising, I am not confident that the next year will be able to sustain that momentum unless there is some kind of a requirement where there is a report produced that lays out the progress that they have made and the potential for sharing and a plan for how they are going to go about achieving it.

Mr. STEARNS. How long should that take?

Mr. BACKHUS. I am going to throw out a number here or a time frame, and not really have a great basis for it I suppose, but it seems reasonable to me to be in the neighborhood of 3 months.

Mr. STEARNS. This report back in 3 months?

Mr. BACKHUS. Yes.

Mr. STEARNS. Considering that the law was passed in 1982 and people have been working on it for almost 20 years, you would think that we could get something tangible.

Mr. BACKHUS. There are a number of issues that need to be worked out, and there are significant barriers.

Mr. STEARNS. They can tackle pharmaceuticals to start.

Mr. BACKHUS. That is true. I am going to be here next week, and there is a tremendous amount of potential.

Mr. STEARNS. Did you say that the savings could be $200 million or $300 million?

Mr. PRINCIPI. The Commission estimated $380 million a year from the joint procurement, joint formularies, universal product numbers, and I believe GAO will be issuing a report soon on the same topic.

Mr. BACKHUS. These are not savings achievable tomorrow. There is a lot of work that needs to be done in order to produce that kind of a savings. The time frame for that would be much longer. The savings essentially are going to result from making medical decisions, if you will, which are the most appropriate drugs and limiting choice to those drugs. Those are difficult things to do and probably will take a couple of years at least.

Mr. STEARNS. There is an annual report that we get that was part of the Percy legislation, but staff tells me that we get it but it isn't much. Again it can be just generalized information which means nothing. How do we put——

Mr. BACKHUS. You are going to have to be specific. In our report it talks about the distinct possibility that the Congress is going to have to be clear on and what it is that they want the agencies to report on and what it is that they expect out of the sharing program.

I agree with you, the report that is issued every year is not very meaningful. It doesn't discuss barriers and it doesn't discuss the amount of activity going on. I think the data are inaccurate. There is a need to pay more attention to this and really deal with the problems in a much more open and forthright way.

Mr. STEARNS. Who actually does the writing of this report?

Mr. BACKHUS. Most of the writing is done by VA. It is considered a joint database and a joint report, but for the most part it is the VA that compiles the information and prepares the report.

Mr. STEARNS. The gentleman from Texas.

OPENING STATEMENT OF HON. CIRO D. RODRIGUEZ

Mr. RODRIGUEZ. I just want to share some comments and I want to get some feedback. I was a legislator for about 12 years, and one of the things that we tried to do with higher education was to try to force the 4-year institutions to talk to the 2-year institutions.

I wanted to get your feedback on that. If you had your druthers, what areas or programs or services would we be doing well in trying to force them to come together through specific legislation that required them to do that?

I know one of the things that we talked about in higher ed and in public ed was just standardizing some of the accounting principles that they had so we would be able to count oranges with oranges and be able to match. I don't know if that is one of the first things that we need to look at to see if we are talking about the same thing, and that is trying to standardize their accounting principles in terms of how they operate.

Secondly, in terms of actual reimbursement and other types of accounting, I know, for example—I am from San Antonio, we have

major hospitals, both VA and the other, and one of the comments I always hear is that the DOD one in terms of their reimbursements, they are not up to par in terms of getting appropriate reimbursement rates. And in each State I know it varies. In Texas, for example, hospitals can require other—and in my particular area ,they service individuals because they also do training. So they service other individuals and a lot of times don't get reimbursed because they don't have the mechanisms to make that happen.

So I would hope that maybe, for example, on reimbursement rates, where they begin to come up to par with the private sector, and both VA and DOD could be one of the areas where they could both benefit. We hold counties accountable for indigent health care, and if one outside county comes into an urban area, we bill the county for that individual that gets hurt.

I wanted to get your feedback. I don't think that we are going to get anywhere until we let them know this is what you need to do. What would you force them to do right now?

Mr. PRINCIPI. Mr. Rodriguez, on cost accounting, we have had some very successful joint ventures between the Air Force and the VA, the joint hospitals in Albuquerque, NM and Las Vegas, NV. They have been successful but they were complicated by the fact that we had different cost accounting systems at the hospitals that created difficulties for both the military and the VA directors who were jointly staffing those facilities. So I think compatible and comparable cost accounting systems and information technology systems, I think we should—the Congress should mandate that the VA and DOD move closer together in those areas.

Mr. RODRIGUEZ. One of the starts would be in terms of making sure that we move forward on accounting principles, that they are comparable?

Mr. PRINCIPI. Yes. As they go to replace their legacy systems in the future, that they look at a joint procurement or at least that the two systems will be compatible.

I think that makes a lot of sense. Just like they are working on the computerized patient record, I think they should do that across the board and we have talked about the procurement areas. I think although some progress is being made, I don't want to represent that no progress is being made in the joint procurement of pharmaceuticals, I think much more can be done.

Mr. RODRIGUEZ. What about the reimbursement rates? If you have an Army hospital and an Air Force hospital and VA, what about that?

Mr. PRINCIPI. Yes, I would think that they should be comparable.

Mr. RODRIGUEZ. And they are not. Some of my hospitals are doing better than others.

Mr. BACKHUS. They have flexibility now, although it is not commonly understood at the local level to charge the going rate, if you will, to be competitive with either the private sector or when negotiating for the other agencies' business. So they have a lot of flexibility there to negotiate a rate that makes the most sense for them and gets them the business. It is not well understood, though. So I think there is a need for the Departments, as we are recommending, to get the word out to these people that they can make the deals.

Mr. RODRIGUEZ. But at the same time, that also causes them to come up with separate types of systems instead of something that is comparable, that can be matched, and where they can all get—be aware of their own systems in terms of reimbursement rates for all of them.

Mr. BACKHUS. That can work both ways.

Mr. RODRIGUEZ. Any other programs or services that you see that might be helpful in terms of moving forward in terms of that sharing?

Mr. PRINCIPI. I believe that beneficiaries of either system should be able to access the other system's hospital on a space-available basis. But allowing beneficiaries to cross lines would be very helpful to beneficiaries.

Mr. RODRIGUEZ. What about a specific pilot project which zeroed in on a few hospitals in terms of looking and providing some incentives to do that pilot project and seeing how that can in the long term—unless we force that pilot project to occur, they are too busy. I would assume that they are too busy doing their thing. They don't have time. Just like when we talked about the 4-year institutions of higher education talking to 2-years institutions, they are too busy unless you force them to do that. Then they came up with the 2-plus-4 programs.

Mr. PRINCIPI. Well-structured pilot programs work. They provide valuable information.

Mr. RODRIGUEZ. Have we had any that we funded and provided incentives?

Mr. BACKHUS. We have joint ventures between the two Departments where they co-locate in the facilities but the administrative structures of those facilities are separate and it complicates things. Those seem to be likely candidates for trying to instill the standardization of administrative structures and systems that could go a long way toward modeling how both Departments could progress.

Mr. RODRIGUEZ. So if we took a community or State and decided to try to establish some kind of a special project or a pilot project that looked at just accounting principles and the reimbursement principles and those kinds of things in terms of standardizing between the VA and DOD and the different types, whether Army or Air Force—and I am sure that the Navy has hospitals, too—and trying to do that?

Mr. PRINCIPI. Yes, sir. I think that makes sense.

Mr. RODRIGUEZ. Thank you.

Mr. STEARNS. I thank the two panelists and now we will go to panel number 2. Thomas Garthwaite, M.D., Deputy Under Secretary for Health, VA; Gwendolyn A. Brown, Deputy Assistant Secretary of Defense, DOD; Lieutenant General Paul K. Carlton, Jr., Surgeon General, U.S. Air Force. I welcome the three of you and I appreciate your patience.

STATEMENTS OF THOMAS L. GARTHWAITE, M.D., DEPUTY UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS; GWENDOLYN A. BROWN, DEPUTY ASSISTANT SECRETARY OF DEFENSE, HEALTH BUDGETS AND FINANCIAL POLICY, DEPARTMENT OF DEFENSE; AND LT. GEN. PAUL K. CARLTON, JR., SURGEON GENERAL, U.S. AIR FORCE

STATEMENT OF THOMAS L. GARTHWAITE, M.D.

Dr. GARTHWAITE. Good morning. Our full statement has been submitted for the record. I would like to make a couple of points.

First, we have developed a close working relationship over the last 3 years in the VA/DOD Executive Council which has yielded significant opportunities and accomplishments in VA/DOD sharing. We clearly regret that a series of communication flaws and unintended incentives, as discussed by Mr. Principi, have allowed our joint sharing efforts to veer off path far more than we wished they had. Once we identified these issues, we have easily been able to get back together and work on some substantive actions to resolve those issues.

We are committed to fixing the sharing function and maximizing the savings and quality of care rendered to our joint beneficiaries. The care delivery sharing issues, however, I think should be viewed against a backdrop of significant success over the past several years. A partial list of important initiatives includes the Military Veterans Health Coordinating Board, incorporating VA centers of excellence in the specialized treatment system, improving cost reimbursement mechanism, joint purchasing of pharmaceuticals which has yielded $20 million in savings so far but is just getting off the ground, standardizing the discharge physical examination, standardizing joint purchasing of medical and surgical supplies which is really ready to take off, collaborating on Y2K, sharing of patient safety initiatives, and clinical guideline development.

Also of importance in our CARES initiative, which is our Capital Asset Realignment for Enhanced Services initiative. We have added a requirement to assess the availability of DOD service or program capacity for potential sharing opportunities. We have mandated this assessment with the cooperation of the Assistant Secretary's office in DOD.

While we have accomplished much, there is much to be done. We are committed to partnering with DOD. On a personal note, the first list of areas for potential collaboration for these meetings was a list that I provided to Dr. Kizer. I have been to nearly every joint meeting since and have served on the Government Computer-Based Patient Record board of directors. I have worked with the Surgeon General to fix problems over time. I believe we are making progress in working together and that we will continue to make progress in the near future.

That concludes my statement and I look forward to your questions.

[The prepared statement of Dr. Garthwaite appears on p. 36.]

Mr. STEARNS. Ms. Brown.

STATEMENT OF GWENDOLYN A. BROWN

Ms. BROWN. Thank you, Mr. Chairman. It is an honor for me to be here today representing Dr. Sue Bailey, the Assistant Secretary of Defense for Health Affairs. She has taken on a new position in the administration and she regrets that she cannot be here today.

With your permission, I would like to submit my full statement for the record and simply summarize key points in my statement at this time.

Mr. STEARNS. Without objection, so ordered.

Ms. BROWN. I am pleased to have the opportunity to share with you and members of the subcommittee the Department's view on the promise, the practice, and the future prospects for health care sharing with the Department of Veterans Affairs. The Department values highly its sharing partnership with the VA. The men and women on active duty today will one day be veterans and become beneficiaries of the veterans' health system. Working in partnership, our two systems are better able to provide health care that our beneficiaries need.

Although the Departments have substantially different missions, we have come to rely upon an agenda for sharing that works, an agenda based on the principle of mutual benefit, and by focusing on joint efforts that benefit both Departments, we are discovering and creating unprecedented ways to capitalize on our respective strengths and expertise not only in the field of medicine, not only when we look at our sharing agreements, but how to better utilize best business practices in the marketplace. As a result, I believe our accomplishments are multiplying.

Since the outset of the sharing program established in 1982, Mr. Chairman, that you have referred to, the vigorous partnering between the VA and DOD facilities have resulted in a growth of the sharing agreements. In the latest report that the GAO has summarized here today, Mr. Backhus indicated that both systems are undergoing significant change. He is absolutely correct. Mr. Principi also referred to change and the challenges, and I agree with both of them.

Since the award of our first regional contract in 1993, the Department has successfully established Tricare throughout the continental United States and Hawaii with 7 regional managed care support contracts. Tricare is critical to the Department's strategy for developing an equitable benefit, with the choice for our beneficiaries emphasizing the use of our military health care facilities or treatment facilities.

On May 14, 1999, Dr. Bailey signed a policy memorandum addressing inclusion of Department of Veterans Affairs health facilities as Tricare network providers and as sharing partners with military facilities. To date, more than 80 percent of VA facilities are Tricare network providers. We ask our Tricare contractors to negotiate reimbursement rates with network providers. And in some instances, when these market rates are set they may be lower than previously negotiated rates under resource sharing agreements.

We will work with the Department of Veterans Affairs and our lead agents as well as our managed care support contractors to simplify and clarify any misunderstandings that have been created.

Over the next few months we are going to review all of our sharing agreements to take a look at the reimbursement rates and other aspects of the agreement as well. Some of those agreements were signed years ago and we definitely need to look at them to make sure that they still apply, utilizing the best business practices. That is our promise.

Dr. Garthwaite and I have worked closely together over the last couple of years—we established the Health Care Financial Management Committee in 1997, and we are going to put this committee to work during the next 12 months to sort out the reimbursement problems which have been raised today.

Clearly the largest sharing between the two Departments is in the area of joint ventures. With joint venture construction or building modifications and sharing of services and facilities and staff, we are able to optimize our resources and tailor the venture uniquely based on the population served, and we have to look at all of these things regionally, State by State, city by city.

At present, DOD and VA participate in joint ventures at four sites. You've heard some of the sites mentioned such as Albuquerque, El Paso, TX—which you are probably familiar with, Mr. Rodriguez—Las Vegas, NV and Anchorage, AK. Planning is underway for three additional joint venture sites in Fairfield, CA; Honolulu, HI; and Key West, FL. I believe that Lieutenant General Carlton will describe the success in Alaska at Elmendorf Air Force Base between the Third Medical Group and the Alaska VA health care system.

DOD and VA have made progress in moving towards and positioning us for the future. Health care is rapidly changing. We cannot let the systems stagnate. DOD and VA, through the Executive Council that was established in 1997, have made I think significant progress. We have chartered, as Dr. Garthwaite mentioned, the Military and Veterans Health Coordinating Board. We have expanded resources sharing and established VA facilities as Tricare network providers. We planned development and acquisition of a common DOD/VA computerized patient record system and established common information technology architectural standards. We have chartered a DOD/VA clinical practices guidelines working group, and we have developed clinical joint practice guidelines for diabetes, smoking cessation, low back pain, hypertension, chronic obstructive pulmonary disease and asthma. And on the agenda, we are looking at other areas such as breast cancer.

We have streamlined the disability and discharge physical examination processes and this is one of the first tasks that we were assigned to do. We have merged the DOD Pharmaceutic Economic Center and the VA Pharmacy Benefit Management Group into a Federal pharmacy executive steering committee, and we have produced a number of joint purchasing contracts for pharmacy and medical and surgical supplies. And we have worked jointly on patient safety and quality care initiatives.

The VA has a unique role in spinal cord injuries, blind rehabilitation, brain injuries. We utilize these centers of excellence and we are going to continue to do so.

In closing, Mr. Chairman, both DOD and VA health care systems face enormous challenges presented by the rapidly changing health

care environment. We have similar missions and we have unique missions. Partnering is a singularly vital effort that allows us to collaboratively pursue creative and innovative sharing approaches beyond just resource sharing at the facility level.

That concludes my summary, Mr. Chairman. I would be happy to answer any questions at your convenience.

Mr. STEARNS. I thank the gentlelady.

[The prepared statement of Ms. Brown appears on p. 41.]

Mr. STEARNS. General Carlton.

STATEMENT OF LT. GEN. PAUL K. CARLTON

General CARLTON. Mr. Chairman, Mr. Rodriguez, members of the committee, I appreciate this opportunity to address the concerns of the Air Force in VA sharing. I will try to be brief and I ask that you accept my complete statement for the record.

Mr. STEARNS. Without objection, so ordered.

General CARLTON. The Air Force has long supported sharing agreements with the VA. Since the formal sharing started by law in the early eighties, the trend has increased to more than 100 agreements to share almost 300 services from radiology to specialized services. The bulk of our partnering occurs at three joint venture hospital sites: Albuquerque, Las Vegas, and Anchorage. These are long-term commitments on both sides of the partnership. Both organizations preserve their organizational autonomy as appropriate at each location. These joint ventures are popular with our patients and they have saved us money.

At Kirtland Air Force Base in Albuquerque, the cost avoidance in fiscal year 1999 was $1.4 million. In addition, patients who use the VA ancillary, specialty, and inpatient care have no out-of-pocket costs, resulting in savings to our Tricare Prime population of another half a million dollars.

In addition to our established joint ventures, construction of a VA clinic has begun at Travis Air Force Base in California, projected to break ground in late 2000.

We have been active participants in the Executive Council, and are delighted with the efforts that we are doing together such as jointly-adopted clinical practice guidelines, computerized patient records to serve our patients, a single discharge physical from the military, cooperation in drug purchasing, and now enhancement of patient safety programs.

The Air Force is currently working with the VA and DOD to establish a new subcommittee to the council, the DOD/VA Health Care Sharing Committee. This will enhance direct sharing and Tricare contracting relationships and assist in resolving issues that detract from our partnering efforts.

Although we are pleased with and proud of our successes, I do need to make clear that sharing agreements or joint ventures with the VA will not work at every Air Force base. If it is a win/win situation for both partners, then of course it makes sense. These arrangements provide an opportunity to save money for the taxpayer while increasing access to health care for the government beneficiary. However, we have found instances where the VA was not the most cost-effective option for the military and vice versa. Travis recently—the VA pulled out of the wing that they were using be-

cause a more cost-effective option was to use the Sacramento facility, the old Mather Air Force Base hospital.

The challenges to sharing include geographic concerns. There are no VA medical centers close to eight of our bases. Another challenge includes concerns about the role of direct sharing versus participation of the VA as part of the Tricare network. Ms. Brown has addressed that.

I believe that the DOD medical contingency and readiness requirements drive a need for two separate systems to support the different missions of the two organizations. Readiness-related activities must remain within DOD control. Those would include resupply of pharmaceuticals, medical supplies for contingency operations, readiness training for Air Force personnel as well as command and control.

While there remains a need for two systems, our existing partnering efforts are critical to ensuring that we optimize the Federal dollar. As both DOD and VA systems have experienced years of fiscal constraints, we are responding together to the need to reinvent or reengineer within the Federal sector. One of our growth industries, we believe, is partnering better with the VA.

In conclusion, I believe there are great benefits to be had on both sides of VA/DOD health care sharing. The arrangements should be carefully evaluated to confirm the benefit before moving forward. I support continuing exploration of how we can capitalize on these efforts in which joint efforts produce positive results for both agencies.

Mr. Rodriguez, in particular to answer your question, we established—this Congress established a pilot program in 1997 called Medicare subvention. That pilot perhaps didn't go far enough or should go further into Medicare and include VA since it is all Federal money. The VA, with an increased capacity to deal with a large number of veterans that are leaving us at an accelerating rate, perhaps opening the access with a funding stream from Medicare might well save Federal dollars.

For the DOD, likewise, dollars can strain much of our business. We continually must send $40,000 hip replacements into a civilian community because we simply don't have the $5,000 to buy the hip prosthesis itself. That Medicare subvention project, we are beginning to realize the fruits of that and perhaps we did not go far enough and perhaps we should have included the partnership with the VA in that Medicare subvention and say it is all Federal dollars. And perhaps, Mr. Rodriguez, San Antonio would be a great spot to do that. We are excited to move into the future. I don't believe the future will be exactly as the past has been. And I am excited for the opportunity to optimize use of our Federal dollars. Subject to your questions, sir.

[The prepared statement of General Carlton appears on p. 47.]

Mr. STEARNS. General, thank you. I guess this is directed to Ms. Brown and Dr. Garthwaite. Obviously Dr. Kizer, when he wrote his memo, was concerned that nothing was happening. He wrote it in April 1999 and it seems about one year after his memo was issued, you folks got into the problem more. It appears to me it is just a case of leadership. Maybe you have so much on your agenda that you can't get to it.

Ms. Brown, how long have you been in office?

Ms. BROWN. February of 1995, sir.

Mr. STEARNS. Just as an outsider talking, and hearing Mr. Backhus of the GAO, it seems like it is just one of you folks getting involved and doing something. Would you agree that the issue here is one of leadership or one of administrative difficulty? There seems no problem in implementing the law. General Carlton is the first one that has talked about cost savings and actual things that are happening, so evidently it is working in the Air Force. Do you care to comment?

Dr. GARTHWAITE. I might just say that we are aware that the policy for Tricare—for VA to register as Tricare providers was in effect and I used to get a significant number of these to sign, so I knew that was happening. We were aware during the budget process that there were some issues with payments and our understanding was that that was moving along and we were moving towards resolution. I think we are all disappointed to realize that it was caught up in this legal opinion. As we began to understand that issue, I think in part from the GAO report but in part from a variety of other reasons, we started talking about it again. I think we quickly realized what the issues are and I think we have quickly taken some actions to fix them. I think it is a matter of how the information came forward in bits and pieces. I think it is just a communications flaw.

Ms. BROWN. Mr. Chairman, I agree with Dr. Garthwaite. I think that we have—through our Tricare contracts. If a VA facility is a network provider, then our Tricare contractor works on the claims process. We were not aware, at this level anyway, that there was essentially a problem except in one region where the contractor did go out to the VA facility to determine what was actually the problem. We are awaiting from the VA the specific details regarding the claims and where there have been any delay in claims payments, we will work with the contractor to make sure that the payment is made.

We also have the issue of the reimbursement rates, whether it is reimbursed at the resource sharing rate or whether the service was provided as part of the negotiated Tricare contract rate. And so we are sorting through these issues.

Mr. STEARNS. Dr. Garthwaite, would you as a VA hospital director attempt to negotiate a new sharing agreement with a military treatment facility, knowing that VA and DOD headquarters were reassessing the whole sharing program? And don't you have a concern that further sharing will languish while the two Departments undertake a lengthy review?

Dr. GARTHWAITE. I talked to the network directors yesterday, told them that we continued to support them, and are working through any concerns that they may have with DOD. We hoped to give them clear guidance on negotiating future contracts and how payments will occur under old ones. As a director, I would be encouraged that it was being addressed forthrightly, and I believe we can make significant progress quickly.

Mr. STEARNS. The gentleman from Texas.

Mr. RODRIGUEZ. Thank you, Mr. Chairman. First of all, I hear that the White House has officially nominated you as Under Secretary for Health?

Dr. GARTHWAITE. Yes.

Mr. RODRIGUEZ. Congratulations.

I made to GAO some comments in reference to a possibility of a special project. And they have talked about incentives, and I know when we talked, General, you mentioned in terms of subvention and they mentioned that it might cost about $1 billion to implement that.

Is there a way—and I would ask all three of you to make comments on this. How do we best go about making some things happen? Is it through a special project type of thing? Also, what kind of incentives? You indicated that you have to have a win/win situation, and I agree; but in some cases I know that just like we are with bogged down doing a lot of stuff, and unless we look at what somebody else is doing, what we are doing is the right thing and everything is right. As a Congressman I am doing everything right until I talk to another Congressman and find out that he is doing some other things that are pretty good. And I assume that the same thing applies here.

How do we make that gel and what kind of incentive can we provide that would cause that to happen? Which areas would you move on? I leave it open to all three of you to make comments.

Dr. GARTHWAITE. I think it is hard to provide incentives in health care. We are pretty clear under fee for service we provided incentives for too much care and expense, and we weren't happy with that. Under managed care we have provided incentives not to give enough health care, and we are not necessarily happy with that. Providing incentives in health care is a difficult proposition.

Having said that, I think we can make significant progress in clarifying benefits for military veterans and retirees. Many are eligible for VA benefits and retiree benefits and many are eligible for Medicare. There is a significant amount of shopping of benefits between the systems that results in wasting of resources and it results in poor coordination of care.

I think if at some point we can get HCFA, DOD and VA to the table to talk about how we can coordinate benefits for veterans, without taking away any benefits from veterans, but rationalizing them so there is a sense of clarity in what they are entitled to and how it is going to be paid for and who is on the hook for that, I think this can be very important.

A critical piece of information to convince you that this occurs in fairly large magnitude, for dual eligible veterans who are eligible for Medicare and VA, we did study where they were in Medicare-Plus Choice plans so HCFA paid $300 million for their care. They came to us for an additional $150 million. So one has to guess that $150 million should have been in the original negotiations for care with the Medicare-Plus Choice providers. There is a significant amount of movement of veterans back and forth between systems based on where they think they can get drug benefits or a variety of other services. Clarifying the benefits and figuring out a rational way to deliver them can make the combined efforts of these three large Departments a whole lot more effective.

General CARLTON. As we work incentives, we are trying to be relevant for the future and we are trying to be at a reasonable price. We are motivated in Federal medicine by customer satisfaction. There is a financial part that, if we tied that, might be useful. Tying that would be reenfranchising our over 65, something that we are trying to do in our Tricare Senior Prime, and we would like to put a portion of our dollars into a fee-for-service system so that our over 65's could come into the Federal sector with their money and save trust fund dollars, but allow us to be a fee for service so we would actually have two systems: the traditional system that we have grown up with and then a fee-for-service system where the more money we generate, the better facilities we have, the better equipment we have, the more surgery we can do, and the more patients we can take care of and the more we can get back in our system.

I believe that type of an incentive would be worthwhile for us. We are looking at that and trying to figure out how to quantify it.

Mr. RODRIGUEZ. You don't charge now fee for service? You take care of a lot of the private sector?

General CARLTON. We take care of the private sector in your town in the trauma arrangement, but not elsewhere. We take care of no one other than to save life, limb or eyesight, other than in San Antonio.

Mr. RODRIGUEZ. The county provides you a couple million but I know that you do a great service to us there. So you are not allowed to do that elsewhere?

General CARLTON. No, we are not. And we would love to, especially with the over-65 crowd.

Mr. RODRIGUEZ. The VA does have a fee for service right now, doesn't it?

Dr. GARTHWAITE. We do bill for certain low-priority veterans, also known as priority 7 veterans. We do some CHAMPVA work. We get reimbursed for that.

Mr. RODRIGUEZ. That would be a good incentive.

Ms. BROWN. We are going to do more in terms of partnering with the VA to achieve the best business and clinical practices and based on the best business decision. One of the ways we are doing that, is with a program at the Department called optimizing health care. We are trying to optimize our system to make it better. As you probably know, we have a huge system and we have huge financial issues that we have to deal with every single year. So we have to really incentivize commanders to do the right thing and make the right choices.

If it makes sense from a business cost analysis to do a risk sharing with the VA to buy or purchase some type of care from a VA facility, I think those commanders in the field have the right to do that. If a commander chooses to use a Tricare contractor and the service is provided by that contractor, that commander has the right to do that.

The issue is how much do we pay for the services, and I think that each of our commanders is having a new and very unique role because of the changing system that we have right now. Because of Tricare we do have to work with outside contractors every single day, and we are trying to build—break down many of the barriers

not only when we are dealing with sharing agreements with the VA but other providers as well. And we are getting ready to launch our new Tricare contract, Tricare 3.0 in Region 11, which is in the States of Washington and Oregon, this will hopefully incentivize our commanders more to look at ways with the lead agent to really optimize our system better.

Mr. STEARNS. The gentleman's time has expired and I thank the members of the second panel. We are going to close the hearing, and I ask unanimous consent that my closing statement be part of the record.

(See p. 21.)

Mr. STEARNS. I would tell all of the participants we expect next year to answer all of these questions when we have you folks back. Thank you, and the meeting is adjourned.

[Whereupon, at 11:40 a.m., the subcommittee was adjourned.]

APPENDIX

Closing Statement
Rep. Cliff Stearns
Chairman, Subcommittee on Health
VA-DoD Sharing Hearing
May 17, 2000

Congress has long held to a policy that seeks to maximize sharing of health resources between the VA and DoD. It's gratifying to know that that policy has yielded some success stories. I'm disappointed that more has not been achieved, though there is certainly no good reason why we can't expand the sharing program in the years ahead.

I'm concerned, however, that we should need to hold hearings on this subject at all. Sharing can benefit not only the taxpayer but the beneficiaries of two Federal departments. Current law provides all the incentives that are needed. I think the issue is leadership. It is unacceptable that problems severe enough to prompt VA's top physician to write to his DoD counterpart should go unresolved. It is unacceptable that such problems should fester and Congress not be notified. We will consider it unacceptable if a policy meant to encourage locally-initiated sharing is undermined by one or both departments "studying it to death". Please assume that we will invite the departments back early next year to answer the questions GAO has raised. I ask the leadership of both departments to work hard to close the gap between the rhetoric on sharing and the reality, and bring us results.

Statement of Rep. Christopher H. Smith (NJ-04)

Veterans' Affairs Subcommittee on Health: VA/DOD Health Care Sharing

May 17, 2000

It is my pleasure to be here this morning to take a closer look at the sharing of health care resources between the Departments of Defense (DOD) and Veterans' Affairs (VA). This hearing provides an opportunity to examine ways in which cooperation between these two departments can be improved, so that costs may be reduced, and beneficiaries in both systems may gain greater convenience alongside continued, high-quality care.

Inter-departmental sharing of health care resources includes local agreements between VA medical centers (VAMCs) and military treatment facilities (MTFs) to exchange inpatient and outpatient care, as well as support services such as laundry. In addition, VA and DOD have worked together so that existing facilities – or the building of new ones – are used for mutual benefit.

In central New Jersey, there is a VA outpatient facility – the Marshall Clinic – which provides excellent primary care for veterans and covers a large geographical area. The Marshall Clinic works with DOD by sending veterans in need of x-rays to a nearby clinic operated by McGuire Air Force Base. This arrangement offers greater convenience to veterans, and might serve as model for future VA/DOD resource sharing. I encourage both DOD and the VA officials to visit the Marshall Clinic.

As with any potential change to the way in which the VA delivers health care, it is essential that our nation's veterans continue to receive the highest quality care available. I believe that VA/DOD sharing can maintain this high standard, while simultaneously providing greater convenience to former service men and women, as in the case of the Marshall Clinic. I know that efforts are already underway to combine the DOD discharge physical with the VA disability compensation examination. This is a reasonable, commonsense project that would greatly facilitate a service man or woman's transition from military to civilian life. I also understand that VA and DOD are also working toward creating interoperable information systems – which would make it easier to access patient records – and are cooperating in the procurement of pharmaceuticals. These efforts should be encouraged.

As Members of this subcommittee take a closer look at DOD/VA healthcare sharing this morning, I am hopeful that we can find new ways to improve delivery – without sacrificing the quality of health care for our nation's veterans.

Statement of Representative Helen Chenoweth-Hage
Full Committee Joint with Senate Veterans' Affairs
Regarding the Legislative Presentation of the Vietnam Veterans of America, The Retired Officers Association, American Ex-Prisoners of War, AMVETS and National Association of State Directors of Veterans Affairs.
345 Cannon House Office Building
March 22, 2000

Chairman Specter and Chairman Stump, I would like to thank you for holding today's hearing. I would also like to thank the these wonderful veterans organizations for providing valuable testimony on how we can better improve the quality of life for our proud defenders.

As you know, the House and Senate Veterans' committees have heard testimony on major issues affecting our veterans' healthcare. The common theme of these testimonies has been the consistent underfunding of veterans' health care by this Administration. Even though we in Congress passed a unprecedented $1.7 billion increase in VA health care last year, this Administration still continues to follow a "do more with less" policy.

We must continue to build on success of this Congress, and we will oppose any efforts by the Administration to undo our legislative gains.

Let me give you an example of the Clinton/Gore Administration attempt to undo our legislative gains. Under the Administration's proposal, co-payment collections totaling $350 million authorized under last year's Veterans' Millennium Health Care and Benefits Act -- signed by the President himself and now Public Law 106-117 -- would be returned to the U.S. Treasury. This is wrong, and I am glad to join Chairman Stump as he leads the effort to ensure that the collections are spent entirely on veterans' health care -- as mandated by the law.

Lastly, I would like to comment on Mr. Boland's testimony with regards to the State Cemetery Grants Program. I think Mr. Boland would be pleased to know that Chairman Stump and I recently sent a letter to Chairman James T. Walsh, Chairman of the Appropriations Subcommittee on VA, HUD, and Independent Agencies, requesting that the State Cemetery Grant Program be fully funded. For FY1999, this program was funded at $5 million and for FY2000 this program was funded at $25 million. It is important to fully fund this program as a token of gratitude to our heroes.

Please know that my commitment to our veterans will never waiver. I will continue to fight for those who sacrificed so much for the defense of our cherished freedom. I look forward to hearing from our distinguished veterans today.

STATEMENT OF
LANE EVANS
RANKING DEMOCRATIC MEMBER
COMMITTEE ON VETERANS AFFAIRS
SUBCOMMITTEE ON HEALTH
Hearing on VA-DOD Health Care Sharing
May 17, 2000

Thank you, Mr. Chairman. I appreciate you holding this hearing today.

VA and the Department of Defense have a long and respected tradition of sharing medical and other resources. Both agencies espouse their support for these agreements. Since the early 1930s, Congress has authorized sharing between government agencies. Specific sharing guidelines for VA and DOD were developed in 1983, almost 20 years ago and Congress has enhanced this sharing authority since that time.

For years, VA and DOD have been alternatively encouraged, prodded and exhorted to engage in sharing arrangements to the extent reasonable to do so. There have been innumerable studies, conferences, and working groups devoted to unearthing and resolving the impediments to sharing health care services between federal agencies. Virtually everyone seemed to agree that it makes sense to optimize the federal government's use of resources when it is possible to do so.

So, what is the status of VA-DOD sharing today? Virtually everyone agrees that sharing is good and should be encouraged where it is mutually beneficial to the agencies and their beneficiaries, but for all of the effort and all of the encouragement we have given these two departments little has been done. The General Accounting Office will tell us that in fiscal year 1998, there were a total of 412 active VA-DOD sharing agreements that constituted less than 1% of VA and DOD's total medical care budgets for that year.

Why haven't the departments engaged in more sharing? Could it be that we have tapped out all of the potential savings with more rigorous management of both systems? After making the fundamental shifts both systems have made from inpatient beds to outpatient and community care settings, the widely held belief that both systems have "excess" services or capacity may be outdated. Still, the concept of sharing has withstood the test of time and there are always opportunities to improve service delivery and efficiency. From this perspective we must

continue to examine opportunities for greater sharing between government agencies.

GAO says part of the reason DOD and VA have not done more sharing is geographical—facilities are just too far away from each other to serve one another's beneficiaries well. Incongruent missions or an inability to fulfill one another's needs also makes greater use of sharing problematic. When a VA Medical Center needs the exact types of care providers or services that a military treatment facility does—say, better access to primary care—it only lengthens queues for both to merge the two groups of beneficiaries. Conversely, if they can come together to create a new resource that serves both—say investing in a piece of expensive technology—it is obviously beneficial to do so.

Recent history of this relationship has tested VA and DOD's fragile commitment to sharing. DOD's health care system is undergoing a significant transition that will largely privatize its delivery effort. It has arranged with fiscal intermediaries to administer the vast majority of its health care funds to reimburse mostly contractually arranged health care provision for its beneficiaries through a program called TRICARE. This transition has caused tremendous upheaval in the military's health care arrangements. Indeed, sharing agreements with VA must be a small concern compared to the upheaval with which Defense officials contend to ensure that its beneficiaries, its providers, and its intermediaries are satisfied with new relationships arising from the transition to TRICARE.

So long-standing sharing agreements have been caught in the balance. Military treatment facilities (MTFs) have truly not understood guidance about how VA fits into their new health care environment. As a result, MTFs are inappropriately sending claims to TRICARE intermediaries instead of reimbursing claims for VA at the locally agreed-upon rates. Not surprisingly, this confusion has led to significant problems with honoring local sharing agreements to reimburse VA. I am guardedly optimistic that soon-to-be-released guidance from DOD will resolve much of this confusion. I hope this guidance will salvage the many effective relationships between the two agencies.

There are some promising national initiatives for VA and Defense. Both must make significant purchases of pharmaceuticals and medical supplies. Leveraging both agencies' purchasing power seems to make sense when negotiating with the titanic pharmaceutical and medical supply manufacturers. There are also efforts underway to assess each system's information technology

needs and to identify if these two systems may be able to interface more closely. I encourage more work on these national initiatives.

I am also pleased this hearing has compelled some activity to fix the broken national sharing agreements with the military for treating catastrophically disabled veterans—most notably those with spinal cord injuries, with traumatic brain injuries and who require blind rehabilitation services. When these medically stabilized soldiers, sailors, airmen or Marines arrive after some serious accident, VA is able to provide seamless care for them from the acute injury phase through their complete rehabilitation. If VA does not see these servicemembers immediately they are often medically stabilized and left to wait at home or in nursing homes until they are medically discharged and officially become veterans or eligible to enter VA's programs on that basis. Unfortunately, for these veterans waiting has a high price tag. Veterans are not able to easily regain the time lost to rehabilitation when they do eventually become eligible for services. If there's any one place we need to straighten out sharing arrangements, it is here and I will monitor proposed policy in this area to ensure that both agencies have resolved their disputes over reimbursement.

Defense and VA each will continue to press forward in ways that meet their own beneficiaries needs—and that's as it should be with two agencies with very different missions, goals and patient populations. Where relationships work to the benefit of the taxpayer, the beneficiaries and the agencies, there is every reason for VA and DOD to cooperate. It will take corporate and entrepreneurial leadership to identify these opportunities and I hope this is what we are encouraging at today's hearing. Thank you, Mr. Chairman. This concludes my statement.

STATEMENT OF ANTHONY J. PRINCIPI
CHAIRMAN
CONGRESSIONAL COMMISSION ON SERVICEMEMBERS AND VETERANS TRANSITION ASSISTANCE

MAY 17, 2000

Mr. Chairman and Members of the Committee, it is a privilege to appear before you this morning to testify on the healthcare findings and recommendations of the Commission on Servicemembers and Veterans Transition Assistance.

You have likely heard the saying that there is nothing constant in this world except for change. And many things have changed over the years gone by and many more will change in the years to come. Change is one reason the Congress created our Commission. Many of the benefits and services provided to the men and women now leaving the Armed Forces and the organizational structures designed to meet them are rooted in the closing days of World War II, more than a half century ago. Our Commission looked at how the country has changed: in the military, in the civilian world and in the Americans who make the transition from one to the other.

We found in some cases benefits and services have become so outdated and program management so ineffective they break faith with those who served and currently serve in uniform. Consistent with these findings, we proposed fundamental and far- reaching reforms to both programs and the governmental organizations delivering them. Our report was without dissent.

The Commission found that access to high quality healthcare is of critical importance to active duty servicemembers and veterans. They consider healthcare to be one of the most important benefits they receive from their military service. We were very impressed with the quality of care provided to servicemembers and veterans and consider both systems to be unique and irreplaceable national resources, critical to the nation and its citizens.

At the same time, however, the Commissioners found that changing healthcare practices, an evolving patient population, infrastructure built for another era and increasing healthcare costs in a time of budgetary pressure will challenge the ability of the two systems, as currently structured, to meet the healthcare needs of their beneficiaries in this new century. We found a true partnership between the VA and DoD healthcare systems offers the best hope for continued access to a continuum of high quality care for the millions of beneficiaries of both Departments. A partnership would allow them to better serve their beneficiaries by making their combined resources accessible to all beneficiaries and allowing the Departments to realize efficiencies from more efficient utilization of their limited resources.

The Commission recognizes the efforts that have been made to establish sharing agreements drawing on the strengths of each Department, but considered in the context of the total beneficiary population and the combined budgets of both Departments, sharing has been incremental and marginal at best. There are several reasons for this:

- Differing administrative, budgetary and personnel systems.
- Each uniformed service's desire to have its own specific providers.
- National traditions and corporate culture.
- Differing catchment areas for DoD and VA facilities.
- Differing eligibility rules and priorities for beneficiaries.

These institutional and cultural barriers to increased cooperation and sharing are part of the reason the Departments project only $62 million of their $33 billion combined budgets will be transferred between Departments as a result of sharing agreements in FY 2002.

The Commissioners believe that the Departments can do better, indeed must do better, if the systems are to remain strong and viable well into this century. Difficult decisions will have to be made within the Departments and the Congress to lower the barriers that impede the creation of a true partnership between DoD and VA. Failure to act will be paid by increasing numbers of beneficiaries who will be forced to turn elsewhere for their healthcare. The Commission has drafted a blueprint that, if adopted, will create the framework for that partnership. A partnership that would maximize the return on the human and physical resources of DoD and VA and increase the number of beneficiaries they treat.

In the short time allotted, it is impossible to cover in any detail the many Commission recommendations to create a partnership in healthcare between DoD and the VA. I will just highlight a few:

- Use the combined purchasing power of both Departments for the procurement of VA-DoD pharmaceuticals, medical surgical supplies and equipment and require the establishment of a joint formulary and universal product numbers. Projected savings of $374 million annually. A DoD Inspector General report recommended that DoD use VA contracts and administration for such purchasing.
- DoD and VA Information Technology systems should be compatible and comparable. VA and DoD currently maintain and use separate computerized medical information systems. Without greater cooperation and joint approaches to IT applications opportunities to enhance the partnership between the two Departments will be complicated, or even foreclosed.
- DoD and VA Cost Accounting systems should also be compatible and comparable. A common cost accounting system would provide the two Departments with the information and data to make sharing decisions on the basis of common understanding. The complications introduced into the otherwise successful VA/Air Force joint ventures in Albuquerque and Las Vegas because of the differing Air force and VA accounting systems illustrates some of the value added by a common cost accounting system.
- Restructure the Budget, Appropriations and DoD/VA policy processes. Both Departments healthcare budgets should be considered together at each stage of the process and a joint policy staff should advise the head of both departments.

Servicemembers and veterans will be the beneficiaries of these recommendations if the Departments and the Congress accept the challenges offered by the changing times and the healthcare recommendations formulated by the Commission in response to them.

Thank you.

United States General Accounting Office

GAO

Testimony

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

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VA AND DEFENSE HEALTH CARE

Rethinking of Resource Sharing Strategies is Needed

Statement of Stephen P. Backhus, Director, Veterans' Affairs and Military Health Care Issues, Health, Education, and Human Services Division

GAO/T-HEHS-00-117

Mr. Chairman and Members of the Subcommittee:

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

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

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

Our survey and fieldwork identified a number of benefits that have resulted from sharing, including increased revenue, enhanced staff proficiency, fuller utilization of staff and equipment, and reduced costs. As required by the law, VA and DOD have reported annually to the Congress on the status of the sharing program and have claimed growth. For fiscal year 1998, VA and DOD stated that virtually all VAMCs and MTFs had sharing agreements under which more than 10,000 services could potentially be exchanged. However, these numbers reflect the number of facilities that have an agreement and the range of services that could be exchanged, but they do not capture the actual volume of services exchanged under the agreements.

Our survey revealed that sharing activity occurred under 412, or about three-quarters, of the existing local sharing agreements. Direct medical care comprised about two-thirds of services exchanged; the remaining one-third included ancillary and support services. However, most activity occurred under a few agreements and at a few facilities. Reimbursements for care provided under sharing agreements—another indicator of activity—were similarly concentrated. Three-quarters of the $29 million in reimbursements for provided care was collected by only 26 of the 146 facilities participating in active agreements. At the joint venture sites, where another $21 million in services was exchanged, we found activity was concentrated at the two locations where VA and DOD integrated many hospital services and administrative processes.

Our work also identified certain barriers that could jeopardize current sharing agreements and limit future collaboration. In addition to inconsistent reimbursement and budgeting policies—two long-standing barriers that we have reported on previously—a more recent barrier has major implications for the nature and future of sharing. Specifically, a 1999 DOD legal opinion and subsequent policy has caused concern among VA and DOD officials that many of these agreements could, in effect, be

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

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

nullified. DOD's contracts with private health care companies through its managed care program, TRICARE, may supersede the sharing of direct medical care between VA and DOD facilities. According to the military Surgeons General and local VA and DOD officials, the policy is causing confusion over what services can be shared. Additionally, changes to DOD payment procedures, initiated without clear guidance to VA or DOD contractors, has exacerbated the situation. According to VA officials, local VA partners are being paid too little, too late, or not at all. Over the past 2 weeks, we have been informed that VA and DOD have taken certain steps to begin to address some of the concerns. However, we have not yet been provided the opportunity to review these steps to determine whether they are adequate to resolve these problems.

BACKGROUND

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

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

Over the past 2 decades, changes in beneficiary populations, resources, and the health care environment have significantly influenced VA's and DOD's health care delivery systems and how the two agencies share health resources. Since 1980, the veteran population has declined from more than 30 million veterans to about 26 million in 1998. VA estimates that the number of veterans will drop to 16 million by 2020. DOD's beneficiary population is also changing. The number of military retirees is increasing and, while the number of active duty personnel is declining, the number of dependents is increasing. Over the past several years, DOD and VA resources have also changed. For example, DOD closed one-third of its MTFs, and VA has consolidated a number of its health care facilities.

To respond to these changes, VA and DOD have made significant changes in their health care systems, mainly adopting managed care principles and shifting care from inpatient to outpatient treatment. In October 1995, VA began to transform its hospital-based health care delivery system into a community-based system. VA developed 22 Veterans Integrated Service Networks (VISN)—geographic service areas defined by patient populations, referral patterns, and facility locations. Each VISN has operational control over and responsibility for a capitated budget for all service providers and patient care facilities, including hospitals.

DOD's health care system has undergone a similar transformation. In March 1995, DOD established its managed health care program, TRICARE, and created 12 service regions, each with a capitated budget primarily based on the total number of beneficiaries in the region. Under TRICARE, beneficiaries can choose one of three program options: TRICARE Prime, similar to a health maintenance organization; TRICARE Extra, similar to a preferred provider organization; and TRICARE Standard, a fee-for-service benefit. Each TRICARE service region is administered by a lead agent who coordinates the health efforts of the three military departments and is responsible for ensuring that the

provider network is adequate. Through competitive bid procedures, DOD contracts with private health care companies for services that DOD facilities are unable to provide.

VA AND DOD PARTNERS REPORT BENEFITS FROM SHARING RESOURCES, BUT SHARING ACTIVITY IS CONCENTRATED

VA and DOD partners responding to our survey attributed a number of specific benefits to their local sharing agreements. As providers, VA survey respondents most frequently cited as benefits increased revenue and fuller utilization of staff and equipment; DOD respondents cited increased medical staff proficiency through, for example, broadening the range of populations physicians treat, such as older patients and patients with more severe or multiple conditions. As receivers, about 70 percent of both VA and DOD respondents cited reduced cost of services and improved beneficiary access and patient satisfaction as benefits to sharing.

Since the sharing law was enacted, VA and DOD have claimed growth in the sharing program, citing increases in the number of facilities with sharing agreements and the range of services that could potentially be exchanged under these agreements. Between fiscal years 1984 and 1994, VA and DOD reported that the combined total of VA and DOD facilities with local sharing agreements had increased from 102 to 284.[8] For fiscal year 1998, the most recent year for which the annual report was issued, VA and DOD stated that virtually all VAMCs and MTFs were involved in sharing agreements. VA and DOD also reported that, between fiscal years 1987 and 1998, the number of services covered under these agreements had increased from 1,387 to 10,586 services. In fiscal year 1998, that number included the services that could be provided by VA through TRICARE.

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

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

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

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

Activity was similarly concentrated at the joint venture sites in Nevada and New Mexico—the two locations where VA and DOD integrated many hospital services and

[8]VA and DOD have reported the number of facilities with sharing agreements since 1984; the actual number of agreements has only been reported since fiscal year 1992.

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

SEVERAL BARRIERS AND CHALLENGES REQUIRE VA AND DOD TO RETHINK RESOURCE SHARING STRATEGIES

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

Long-Standing Barriers Continue to Jeopardize Sharing

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

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

TRICARE Policies Call Into Question Current and Future Sharing

A number of VA and DOD officials, including each service's Surgeon General, stated that TRICARE has the potential to limit the services VA provides under the sharing program. In response to a DOD legal opinion stating that local sharing agreements for direct medical care constitute competing networks with TRICARE contractors, DOD issued a policy memorandum in May 1999. This policy has caused concern among VA and DOD officials that many of these agreements could, in effect, be nullified. According to the legal opinion, MTFs are required to refer DOD beneficiaries to TRICARE network providers for health care when such care is not available at the MTF. The legal opinion further states that referring a beneficiary to a VAMC sharing partner violates the TRICARE contract unless the VAMC is a member of the network. While the policy still allowed sharing for support services, it called into question the local sharing agreements in which VA provided direct medical care, which comprise about 80 percent of the

services covered under the agreements that were reported to us as active.

DOD also issued a policy transferring funding and payment responsibility for MTF-referred care—primarily for active duty members—from the MTFs to TRICARE support contractors, effective October 1, 1999. VA officials told us that since this new policy went into effect, VA sharing partners have been paid late, have received payments for services provided under sharing agreements at less than the sharing agreement negotiated rate, or have not received payment at all. These payment problems are the result of VA's and the TRICARE contractors' different billing processes and the lack of clear guidance from DOD. For sharing agreements, VA submits one bill for all medical and professional services, whereas TRICARE requires itemized bills for each service. Therefore, when TRICARE support contractors receive bills for sharing agreements, they often reimburse for only one service, resulting in VA not getting reimbursed for a number of the services it provided. According to VA officials, this policy has negatively affected collaboration and unless addressed will continue to be a disincentive to future efforts. We recently learned that VA and DOD have taken certain steps to begin to address some of these concerns, but we have not yet been provided the opportunity to review these steps to determine whether they are adequate remedies.

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

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

CONCLUSIONS

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

Notwithstanding the recent steps reportedly taken to address certain barriers, VA and DOD will still need to consider the criteria and conditions that make resource sharing a cost-effective option for the federal government—not for VA or DOD alone. To determine the most cost-effective means of providing care to beneficiaries from the federal government's perspective, we have recommended that the Secretaries of VA and DOD jointly assess how best to achieve the goals of health resource sharing, considering the changes that have occurred over the last decade in the VA and DOD health care systems and the populations they now serve. In addition, we recommended that the agencies jointly address the barriers that have impeded sharing and collaboration, by

establishing procedures to accommodate each other's budgeting and resources management functions as well as facilitate timely billing, reimbursement, and agreement approval. To provide stability to the current sharing program while DOD and VA reassess how best to achieve the goals of resource sharing legislation, we also recommended that the Secretary of Defense direct the Assistant Secretary (Health Affairs) to review and clarify DOD's policy on the extent to which direct medical sharing is permitted with VA.

In commenting on a draft of our report, VA and DOD generally agreed that there are opportunities to improve the administration of the sharing program. VA did not concur with our joint recommendation because it believes it has taken strong actions to improve efforts to reach program goals. While DOD concurred with the joint recommendation and agreed to reassess its policies' effects on the sharing program, it noted that the policy on TRICARE does not prohibit sharing, which seems to contradict its legal opinion on TRICARE. As the health care environment in which VA and DOD share resources continues to evolve, VA and DOD will likely continue to be challenged in their collaborations on how best to make effective use of excess federal health care resources. In the event that the two agencies are unable to resolve their differences in a reasonable amount of time, we suggested that the Congress consider providing direction and guidance to clarify the criteria, conditions, roles, and expectations for VA and DOD collaboration.

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

Statement of
Thomas L. Garthwaite, M.D.
Deputy Under Secretary for Health
Department of Veterans Affairs
On
VA-DOD Health Care Sharing
Before the
Subcommittee on Health
Committee on Veterans' Affairs
U. S. House of Representatives

May 17, 2000

I am pleased to be here this morning to speak to you about the promise, challenges, and prospects for the sharing of health care resources between the Veterans Health Administration (VHA) and the Department of Defense (DoD) military health system (MHS). VA fully supports Federal healthcare sharing as a means to improve the quality and efficiency of services provided to Federal beneficiaries, particularly in instances where beneficiaries are dually eligible for health care services. DoD is our single largest sharing partner. We welcome opportunities to provide healthcare to members of the military and the retiree community when we are able to do so.

Background

The "Veterans' Administration and Department of Defense Health Resources Sharing and Emergency Operations Act", Public Law 97-174, enacted in 1982, dramatically facilitated sharing arrangements between VA and DoD health care facilities. Virtually all VA medical centers and nearly all military treatment facilities (MTFs) have been involved in sharing agreements under this authority. The expansion of VA-DoD sharing authority in 1995 to allow VA facilities to participate in TRICARE provider networks added a new dimension to our relationship with DoD. Consistent with this law, VA's primary focus is on providing quality care to our nation's veterans and, when resources are available, to DoD beneficiaries.

VA/DoD sharing has been widely recognized and endorsed as an effective means to provide better service to Federal beneficiaries cost effectively. The Congressional Commission on Servicemembers and Veterans Transition Assistance in its January 14, 1999 report stated that it ". . . envisions a DoD/VA healthcare partnership offering beneficiaries a seamless transition from one

- We plan to further review business practices to assure that those practices optimally support direct sharing and VA participation as a TRICARE provider.
- We plan to review case handling or case management – particularly involving patient movement to our centers of excellence and to VA national specialized programs.
- Over the next year, we plan to jointly review all existing agreements to assure that they optimally support our joint goals.
- We will also review issues raised by the GAO in its recent review of this program.

Other Health Resource Sharing

In addition to our efforts to resolve issues regarding direct care delivery sharing, there is significant cooperation in several other areas. With leadership from the VA/DoD Executive Council a number of important initiatives have been completed or are underway.

VA recently entered into a Memorandum of Agreement (MOA) with DoD to combine the purchasing power of the two Departments and eliminate contracting redundancies. The MOA has two appendices--one dealing with pharmaceutical, the second encompassing medical and surgical supplies. A third appendix, dealing with high-tech medical equipment, is under consideration. Regarding pharmaceutical standardization and joint procurement, staff from VA's National Acquisition Center, Pharmacy Benefits Management Strategic Healthcare Group, DoD's Pharmacoeconomic Center and Defense Support Center-Philadelphia are working together to address joint pharmaceutical procurement. Through joint committed use volume contracts we have already accomplished over $19 million savings annually from these efforts. Savings from these efforts help both Departments reduce health care costs.

In our role as primary backup to the DoD health care system, in times of war or national emergency, we are working with DoD in their development of an automated system to globally track and provide in-transit visibility of military evacuees to DoD and VA medical facilities. Interagency requirements to share both bed availability and patient information will be included in the U.S. Transportation Command's Regulating and Command and Control Evacuation System ($TRAC^2ES$). In addition, VA is collaborating with the Public Health Service to identify requirements for the National Disaster Medical System, which addresses civilian disaster needs. All of these projects were undertaken to overcome current difficulties associated with manually exchanging paper-based patient information.

The Government Computer-based Patient Record (GCPR) Project is a collaborative activity to create interoperability among information systems.

Together VA, DoD and Indian Health Service are creating an electronic framework, which will allow us to easily and securely exchange medical information. This will enable us to provide better quality care to veterans, military personnel and their family members, and members of Native American tribes. The framework will develop and promulgate open standards for the sharing of health information and its security. The effort has the support of HCFA and has the potential to accelerate data interchange standards across the health care industry.

VA and DoD have made progress in the sharing and joint development of clinical practice guidelines. Guidelines for diabetes, smoking cessation, low back pain, hypertension, chronic obstructive pulmonary disease and asthma have been finalized in cooperation with other Federal health care organizations. During the next two years, we will be working on guidelines for pain management, preventative services, major depressive disorders, gastro-esophageal reflux disorder, substance abuse, uncomplicated pregnancy, and redeployment health concerns.

VA and DOD jointly are taking a leadership role in the promotion of patient safety. Through the National Patient Safety Partnership, we developed a "best practices" initiative to reduce preventable adverse drug effects, and we are identifying ways of sharing patient safety "lessons learned". VA's mandatory reporting system is being adopted by DoD and our voluntary reporting system is being constructed to add DoD in the future if they wish.

At selected sites we have combined the military's discharge physical with VA's disability compensation examination for those service members applying for VA compensation benefits. VA is working cooperatively with DoD and HHS to establish a Military and Veterans Health Coordinating Board to oversee a variety of health care and deployment issues and build upon the accomplishments of the Gulf War Coordinating Board.

A number of these efforts parallel, or are a direct result of, recommendations of the previously mentioned Congressional Commission on Servicemembers and Veterans Transition Assistance. These include the streamlining of the disability physical examination process, the expanded use of combined purchasing power, and ongoing efforts to standardize information technology development.

Millennium Act Implementation

I would like to address briefly the status of implementation of Section 113 of the Veterans' Millennium Health Care and Benefits Act (Public Law 106-117) that provides for reimbursement to VA for medical care provided to eligible military retirees. The law calls for a Memorandum of Agreement (MOA) to be in effect by August 31, 2000.

system to the other, providing beneficiaries the highest possible return on the human and physical assets invested in the two systems while at the same time empowering each Department to fulfill its unique missions". The 1999 Defense Authorization law, Pubic Law 105-261 strongly endorsed the ongoing VA and DoD efforts to share resources and encouraged expansion of both health resource sharing and VA participation in the TRICARE program.

We note, furthermore, that sharing between DoD and VA may be subject in some respects to the medical privacy rules now being promulgated under the Health Insurance Portability and Accountability Act of 1996. The Department of Health and Human Services (HHS) issued proposed regulations last October. HHS has stated that it expects to issue final regulations this year for the handling of personal health information, including for such information held by Federal agencies. Both DoD and VA are participating with HHS in the inter-agency process to develop the final regulations.

Direct Health Care Sharing

A snapshot of VA/DoD health resource sharing activities (as of April 27, 2000) shows that there are 846 agreements (excluding TRICARE). VA medical facilities have agreed to provide 7,734 services to the MHS, while the MHS has agreed to provide 1,047 services to VA. In Fiscal Year 1999 VA earned $32,194,216 from sharing agreements while purchasing $23,853,957 in services from the MHS. TRICARE earnings in Fiscal Year 1999 were $4,897,427. Earnings from both programs increased from Fiscal Year 1998.

We are currently working with DoD to resolve issues that arose in Fiscal Year 1999 due to diverging business practices. Briefly, these issues involve confusion regarding the effect of TRICARE on the status of local sharing agreements between VA medical facilities and MTFs and difficulties that some of our medical facilities have experienced in receiving appropriate reimbursements. Similar issues also arose concerning services provided by VA in TRICARE Remote sites.

Efforts to Resolve Direct Health Care Sharing Issues

Dr. Bailey and I, along with our respective staffs, are committed to resolving any remaining issues concerning our joint sharing programs and to expanding these efforts when it is mutually beneficial. Of particular note, Dr. Bailey has taken a major step toward resolving these issues by issuing a directive clarifying the status of VA/DoD sharing agreements and requiring that payments related to those agreements be made at the rates specified in the agreements. We have also agreed to take additional steps under the auspices of the VA/DoD Executive council to assure that our sharing programs are functioning optimally:

OMB is working with VA and DoD to help develop a mutually acceptable agreement. OMB, VA, and DoD have formed a joint work group to draft such an agreement. We will continue to work to implement this provision.

Future

In the future, federal beneficiaries and the programs that serve them would be improved by seamless coordination of federal benefits. Today, a veteran who is a military retiree may have benefits from VA, DoD, Medicare and private insurance. As an unintentional result, they may have incentives to seek treatments and medication coverage from whatever system offers the least out of pocket expense. The opportunity to coordinate care for better quality and efficiency is lost in the process. An approach which first defined the benefits for each person and then optimized their choice of delivery systems would improve the patchwork set of rules and systems that has evolved.

Summary

Both VA and DoD remain committed to increasing resource sharing to not only achieve the efficiencies that are possible, but also to better serve the veterans, retirees and active duty service members that rely on us for health care services. Our goal is to achieve a seamless transition of former service members from one system to the other and, when joint sharing is possible and beneficial, to provide the highest possible level of quality health care services to the patients being served. Steps have already been taken to resolve payment issues concerning our sharing agreements with the MHS and we have agreed to jointly conduct a thorough review of sharing with the MHS and VA's participation as a TRICARE provider to assure that we have explored every opportunity to enhance these programs. VA is confident that with resolution of current challenges, the longstanding and beneficial sharing relationships will continue to grow for the benefit of both the taxpayers and the patients that we serve.

This concludes my statement. I will be pleased to answer any questions members of the Subcommittee may have.

GWENDOLYN A. BROWN

Deputy Assistant Secretary of Defense
(Health Budgets and Financial Policy)
Office of the Assistant Secretary of Defense for Health Affairs

Ms. Gwendolyn Brown was appointed by President Clinton to serve as the Deputy Assistant Secretary of Defense for Health Budgets and Financial Policy in February 1995. She is the principal DoD official responsible for overseeing the Defense Health Program, which includes the $15 billion budget for the Military Departments and Defense components. She coordinates the Office of Health Affairs' development, review, and issuance of Defense Guidance and the five year Program Objective Memorandum. Ms. Brown is responsible for submitting a balanced and comprehensive Department Health Budget and for congressional coordination of the submission. She works closely with the Military Services and components to promote cost-effective medical resource management policies and quality health care for over 8.2 million beneficiaries of the Military Health System (MHS). Ms Brown represents the Department with other Federal agencies to develop health financing policy, financial programs, and health system performance measures. She is the Department's senior Health Program resource manager.

Prior to her appointment, Ms. Brown was the chief of staff and legislative director to Congressman Julian C. Dixon, a senior member of the House of Representatives from California. Ms. Brown directed the Congressman's legislative agenda, managed his leadership activities, and was responsible for defense appropriations and foreign policy matters. Before joining Congressman Dixon's staff, Ms. Brown served as an international trade specialist at the U.S. Department of Commerce. She advised administration officials and company executives on the economic conditions and investment opportunities in the Middle East region and nontraditional markets. She has led several business trade missions to North Africa, and coordinated the first U.S.-Moroccan Joint Commission meeting in Rabat, Morocco. Ms. Brown has held faculty positions at the California State Polytechnic University at Pomona and at the University of Massachusetts.

Ms. Brown has received numerous professional and civic awards. She was awarded the bronze medal--at that time, the highest medal of distinction awarded by the Department of Commerce for superior federal service.

Ms. Brown received her Bachelor of Arts Degree from the University of California at Santa Barbara, a Masters Degree from the University of California at Los Angeles, and completed advanced graduate studies at the Fletcher School of Law and Diplomacy at Tufts University in Massachusetts.

Ms. Brown, a native of Los Angeles, California, is married to Cameron Byrd. They have one daughter and reside in Maryland.

Mr. Chairman, it is an honor for me to be here today representing Dr. Sue Bailey, Assistant Secretary of Defense for Health Affairs. I am pleased to have this opportunity to share with you and the members of the Subcommittee the Department of Defense's (DoD) view on the promise, practice and future prospects for healthcare sharing with the Department of Veterans Affairs (DVA). Mr. Chairman, it is important for you to know that DoD values highly its sharing partnership with the VA. The men and women on active duty today will one day be veterans and become beneficiaries of the Veterans health system. Working in partnership, our two systems are better able to provide the healthcare our beneficiaries need.

Although our two Departments have substantively different missions, we have come to rely upon an agenda for sharing that works -- an agenda based on the principle of mutual benefit. By focusing on joint efforts that benefit both Departments, we are discovering and creating unprecedented ways to capitalize on our respective strengths and expertise. As a result, our accomplishments are multiplying and our potential is exceeding expectations.

Today, our commitment to pursue jointly this common goal involves leadership in its broadest sense. In an effort to revitalize sharing efforts by fostering an environment that supports collaboration and change, together we formed the DoD/VA Executive Council. The Council consists of the Departments' respective chief health officers and their key deputies and the Surgeons General of the Military Departments and focuses on the areas of health care delivery, research, planning, information, policy, and performance. The Council, which was formalized in February 1998, oversees and facilitates a robust agenda of joint initiatives aimed at finding ways to improve beneficiary health in the system within available resources.

Since the outset of the sharing program, established under the 1982 legislation, the vigorous partnering between VA and DoD facilities resulted in the growth of sharing from a few agreements in the early years to over 800 today. The number of sharing agreements continued to grow, even during the rightsizing of the Military Health System as part of the Base Closure and Realignment process.

In its latest report on VA/DoD resource sharing, the General Accounting Office (GAO) emphasized the fact that our two healthcare systems are undergoing significant changes. That is absolutely correct, and as our respective healthcare systems continue to shape themselves for the future, we have agreed that our partnering is best strengthened through joint efforts that are of mutual benefit, or, at the risk of sounding trite, are win-win relationships. As our military forces and medical facilities downsize, opportunities for sharing emerge. One opportunity is in the cost-effective joint use of facilities. For example, VA Medical Centers are now occupying clinic space provided by nine military facilities as a part of VA's community based clinics program. The VA Medical Center at Murfreesboro, Tennessee and the Air Force's Arnold Engineering and Development Center share space and medical services at VA's outpatient clinic at the Air Force's Tullahoma Base, about 50 miles southeast of Murfreesboro. At that clinic, five full-time VA clinicians provide primary care to about 2,000 area veterans and the base's active duty beneficiaries. The success of the arrangement has brought more beneficiaries to the clinic, and the VA is considering expanding space at the clinic.

Today, the Defense Department relies more frequently on our Reserve Component personnel to meet the National Security missions of our country. This reliance means activating Reservists who require physical exams, dental screenings and immunizations. Many of our Reserve Component units enter sharing agreements with VA facilities in order to meet these health requirements for their unit personnel. For example, The 81st Army Reserve Regional Support Command negotiated a regional agreement with four Veterans Integrated Service Network (VISNs) (VISNs 7,8,9 and 16) having medical centers located in seven southern states and Puerto Rico for VA to provide physical examinations, dental screenings, and immunizations to reservists. VA provides professional resources, clinical facilities, and supplies necessary for these services. Plans are being considered to expand these regional agreements to other parts of the country.

In DoD's eyes, the value of this relationship remains high and the VA network of medical facilities continues to constitute an important component of the military healthcare system. Sharing with the VA is as important now as it has been at anytime since the 1982 enactment of the sharing legislation. The time and energy devoted by the two departmental staffs in the development and implementation of both traditional and innovative sharing programs represent clear testimony to the strength of the relationship. In that regard, in response to the GAO recommendation that DoD reassess its policy restricting sharing of direct medical care, we responded that DoD does not have a policy restricting VA/DoD sharing. In reevaluating the policy, DoD found that the policy has been misinterpreted in several instances. We now have a clearly stated policy on sharing, both with the DoD medical facilities and in the TRICARE networks.

Our policy reaffirms and clarifies that all VA-DoD sharing agreements for the Supplemental Health Care Program (care provided to active duty and reserve personnel) are authorized and prompt payment will be made by the Military Treatment Facility (MTF) at rates negotiated in the agreements. The policy also reiterates the primacy of the National VA-DoD agreements for Spinal Cord Injury, Traumatic Brain Injury and Blind Rehabilitation for catastrophic care of active duty and reserve members. The pre-eminence of the VA in these specialties is unquestioned, and the DoD will provide a more systematic approach to inform MTFs, Lead Agents, and Managed Care Support Contractors of procedures to refer to VA facilities these serious traumatic injury cases. The DoD will ensure that our military members obtain the best quality care for Spinal Cord Injury, Traumatic Brain Injury, and Blind Rehabilitation and reimburse the VA's centers of excellence at the full rates negotiated in these national agreements.

We do note, furthermore, that sharing between DoD and VA may be subject in some respects to the medical privacy rules now being promulgated under the Health Insurance Portability and Accountability Act of 1996. The Department of Health and Human Services issued proposed regulations last October. HHS has stated that it expects to issue final regulations this year for the handling of personal health information, including information held by federal agencies. Both DoD and VA are participating with HHS in the inter-agency process to develop the final regulations.

In the late 1980's, escalating costs of health resources led the Department of Defense to initiate managed beneficiary care and aggressive cost controls in order to ensure that our patients continued to have access to high quality care. As a result, in 1993, the first regional contract for the new DoD managed care program, TRICARE, was awarded. A combination of military medical facilities and Managed Care Support contracted network providers, TRICARE now enables us to respond to the needs of our patients with no degradation in the quality of health care. To ensure that DoD beneficiaries continued to have access to a wide range of options, and that VA would continue as a key partner in our system of the future, we jointly developed a memorandum of understanding in 1995. That memorandum allows VA Medical Centers to negotiate with the TRICARE Managed Care Support Contractors to become contractor network providers. Since the implementation of that agreement, 138 VA medical centers, or roughly 80%, have negotiated agreements with the TRICARE contractors to provide health services.

The enormity and complexity of the TRICARE contracts will occasionally lead to network problems related to provider billing and claims processing. Technically, these are contractual relationships between TRICARE contractors and their network providers. However, we have a strong commitment to our beneficiaries and network providers to facilitate solutions to these problems and to ensure continued quality healthcare. So, as we learn of specific problems, we work with both the contractors and the network providers, such as the VA facilities, to come to a prompt resolution. We have identified that some VA facilities are experiencing problems with claims payment, and are working with VA to gather necessary claims payment data in order to resolve the issue. Once we have the data, our contracting staff will expeditiously resolve the problem.

An excellent example of sharing success that will carry into the future is that of joint DoD/VA acquisition of medical supplies. DoD and VA have signed a Memorandum of Agreement (MOA) that combines the strengths and buying power of VA with those of DoD. The expected result is to lower medical materiel costs and to eliminate redundancies in contracting. The goal of the MOA is to combine identical medical supply requirements from both departments and leverage that volume to negotiate better pricing. The organizational goals are to eliminate duplication of contracting effort and allow customers of both departments to select products and pricing that best meet their needs. DoD and VA will continue to contract for their own prime vendor distribution services but over time commodity contracts will be converted to VA contracts.

Another major area of VA/DoD sharing continues to be joint venture construction or modification of healthcare facilities. At present, DoD and DVA participate in joint ventures at four sites: Albuquerque, NM; El Paso, TX; Las Vegas, NV; and Anchorage, AK. Planning and associated construction is underway for three additional locations: Fairfield (Travis AFB), CA; Honolulu, HI; and Key West, FL. These ventures involve sharing services, facilities, and staff. Each venture is unique based on the needs of the populations served, and they have proven to be very satisfying to the patients as well as successful in eliminating duplication. An example of this is the opening of the new VA/DOD joint venture replacement hospital at Elmendorf AFB in Anchorage, Alaska in May 1999. This is an Alaska VA Healthcare System and Regional Office and Air Force 3rd Medical Group jointly operated facility at Elmendorf Air Force Base. This 110-bed facility cost approximately $160 million; VA contributed over $11 million toward construction. Currently, VA staffs and manages the 10-bed intensive care unit. VA also provides staff for the emergency room, the integrated internal medicine/cardiopulmonary

department, administration, patient services, utilization management, social work, credentialing, and surgical services. In FY 1998, VA patients accounted for a total of 282 bed days of care in the hospital. By comparison, in FY 1999, VA patients accounted for over 1,200 bed days of care. This one instance signifies a joint venture's ability to help each partner achieve its missions and become stronger, more robust healthcare providers.

DoD and DVA have also agreed to share existing automation and technology products and to collaborate on current and future developments. We have joined in medical automation research in the Defense Information Research Center. We have linked DoD's Composite Health Care System (CHCS) and VA's Veterans Health Information Systems and Technology Architecture (VISTA), successfully tested clinical laboratory data exchange, and accelerated evaluation of off-the-shelf software in the automation of patient records. Sharing information about our patients, particularly when our two agencies may treat the same patient is vital to continuity of care. DoD and VA, in conjunction with the Indian Health Service (IHS) continue to work on the Government Computer-based Patient Record.

DoD and VA have a Memorandum of Agreement for the use of DoD's medical evacuation system. VA is participating in the development of evacuation information systems that will enable VA to enter patient data directly. When in full operation all of these systems will greatly ease the delivery of patient care.

On December 7, 1999, the President directed federal agencies to take a number of actions to improve patient safety. DoD and VA are meeting that direction through collaboration on various efforts, such as the development of clinical practice guidelines. Together we are working on the presidentially directed Quality Interagency Coordination Task Force, or QuIC. The QuIC was established to enable federal agencies with responsibility for healthcare to coordinate their activities to measure and improve the quality of care and to provide beneficiaries with information to assist them in making choices about their care.

Mr. Chairman, we have a deep commitment to preserving the health and well being of our military members and our veterans. In that regard, we have many activities underway to improve monitoring of individual health status and the continual medical monitoring and recording of hazards that might affect the health of service members, who will eventually become veterans. Following the tremendous efforts by both DoD and VA health personnel in creating and implementing the Comprehensive Clinical Evaluation Program (CCEP) and the Uniform Case Assessment Protocol (UCAP) for Gulf War veterans, interagency coordinating boards have been established.

The Persian Gulf Veterans Coordinating Board, created in January 1994, provided direction and coordination on health issues related to the Gulf War. TheBoard has used three working groups, Clinical, Research, and Disability Compensation, to achieve very successful interagency cooperation and coordination. This coordinating board was the model for the recently established Military and Veterans Health Coordinating Board (MVHCB).

Like the Persian Gulf Board, the MVHCB is chaired by the Secretaries of Defense, Veterans Affairs, and Health and Human Services. The purpose of the MVHCB is to ensure a fully coordinated, synergistic and interagency approach to enhance health protection for active

duty personnel, veterans and their families relating to future deployments. The MVHCB has three working groups addressing research, deployment health and risk communications.

DoD and VA share in research in addition tothat targeted to Gulf War Illnesses. Together, DoD and VA have funded biomedical research addressing post-traumatic stress disorder, infectious diseases, prostate cancer, traumatic brain injury, spinal cord injury, emerging pathogens, wound healing and repair, and research related to specific populations such as women and homeless veterans.

Due to the combined size and resources of the VA and DoD health systems, as well as the geographic dispersion of the agencies' facilities, opportunities for sharing resources and saving federal dollars are many and significant. More than ever before, sharing among federal healthcare providers is relevant and necessary to support the cost-effective delivery of quality healthcare for federal beneficiaries. Through the efforts of our Executive Council we will continue to identify and pursue such agreements.

In its report on VA/DoD sharing, GAO also recommended that the two Departments assess the current sharing programs to determine the changes needed to achieve our healthcare goals. We concurred with that recommendation. We also stated that the committee structure of the VA/DoD Executive Council permits us to work together to implement the recommendation.

Mr. Chairman, we recognize that we must develop creative and innovative approaches to healthcare delivery in order to better serve our beneficiaries in this rapidly changing healthcare environment. Both DoD and VA healthcare systems face enormous challenges presented by this environment. Within the Department of Defense we must strive to meet these challenges with declining resources, growing expectations of our beneficiaries, and most importantly, with increasing requirements of operational missions.

Mr. Chairman, the most important health mission of DoD is to preserve and to protect the health of our fighting forces. These men and women march, sail and fly into harm's way each time the Nation asks that they do so. We must be there for them in Bosnia, Saudi Arabia, Kosovo, and Korea. And we must assure them that we will care for their families' health needs while they are gone.

Partnering with the VA is a significant collaborative effort that allows us to pursue new sharing models. These models will help both departments to meet our similar and our unique healthcare missions.

DEPARTMENT OF THE AIR FORCE

PRESENTATION TO THE COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

SUBJECT: VA/DOD HEALTH CARE SHARING

STATEMENT OF: LIEUTENANT GENERAL PAUL K. CARLTON, JR
SURGEON GENERAL
UNITED STATES AIR FORCE

17 MAY 2000

NOT FOR PUBLICATION UNTIL RELEASED
BY THE COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

Mr. Chairman and members of the Committee, I am Lieutenant General Paul K. Carlton and I appreciate the opportunity to address this committee on VA/DOD health care sharing.

The Air Force has long supported sharing agreements with the VA. In terms of numbers of facilities and agreements, the trend has been an increase in resource sharing between the Air Force and the VA since formal sharing began in the early 1980s. The Air Force has more than 100 sharing agreements with the VA to share almost 300 services from radiology to specialized services such as hyperbarics. The bulk of our partnering activities occur at our three joint venture hospital sites: Albuquerque, Las Vegas and Anchorage. These are long-term commitments on the part of both partners. Both organizations preserve our overall organizational autonomy as appropriate at each location. At the joint venture at the 377th Medical Group at Kirtland Air Force Base in Albuquerque, the Air Force built a separate outpatient clinic which is managed by the Air Force. The Air Force Commander works closely with the Veterans Administration Medical Center Administrator to ensure efficient oversight of the joint venture. Services such as the emergency room, laboratory, and radiology departments were integrated with the VA, creating jointly staffed and operated services within the Veterans Administration Medical Center. The result is a maximizing of the resources at both facilities while ensuring beneficiaries receive quality care in a timely and cost-effective manner. At Kirtland, Air Force providers can admit to VAMC inpatient units, or refer active duty and families to specialty care within the VAMC. The Air Force has access to the VA computer system (VISTA) and military providers can function the same as VA providers by ordering tests, viewing results, and entering other healthcare data as needed in conjunction with a DOD admission to a VA bed. The estimated cost avoidance was in excess of $1.2 million in Fiscal Year 1998 and $1.4 million in Fiscal Year 1999. The avoided costs were the result of utilizing the joint venture rather than the local community. Additionally, beneficiaries who use the VA ancillary, specialty and inpatient care have no out-of-pocket cost shares, resulting in savings to our Prime enrollees of an estimated $450,000. The arrangement ultimately utilizes excess capacity at the VAMC and reduces the government's CHAMPUS/TRICARE catchment area costs. Although

the joint ventures do not generate high dollars of external revenue, the tight intertwining of interests at the local level leads to avoidance of costs.

The Mike O'Callaghan Federal Hospital (MOFH) at Nellis Air Force Base in Las Vegas maintains 62 Air Force and 52 VA beds. The Air Force Commander is dual hatted as the MOFH Chief Executive Officer. The 99th Medical Group operates with the VA under both an integrated and collocated concept. As the joint venture developed, decisions were made about the appropriate organizational arrangement to meet the mission requirements of the Air Force and VA. As a result, in integrated work centers, the Air Force and VA staffs work side-by-side. These arrangements occur in the emergency department, surgical suite, intensive care unit and the pharmacy. Other work centers are staffed by the Air Force or VA exclusively. For example, both Air Force and VA have separate inpatient units.

Our newest joint venture in Anchorage, Alaska, partners with the Alaska VA Healthcare System and Regional Office and the 3rd Medical Group, Elmendorf Air Force Base. The VA has never had a dedicated inpatient facility in Alaska. The new joint venture is a replacement for the military hospital located in Anchorage and it began operation in May 1999. Under our agreement with the VA, they contributed $11.2 million of the $164 million in new construction costs. A central Executive Management Team directs and manages development and execution of the different components of the joint venture. Functional teams manage specific areas. For example, the VA staffs and manages the 10-bed intensive care unit. VA also provides staff for the emergency room, the integrated internal medicine/cardiopulmonary department, administration, patient services, utilization management, social work, credentialing, and surgical services. The Air Force staffed and operated multi-service unit (inpatient ward) is available for VA admissions. The Air Force recovers its operating costs while avoiding a projected $1.4 million annual expenditure on local civilian-provided intensive care. The VA gains an inpatient facility for treatment of the sickest veterans and avoids an estimated $4.3 million in civilian provider expense.

The Air Force continues to be directly supportive in partnering with the VA. Construction of a VA clinic has begun at Travis AFB in Northern California. The new clinic is projected to begin operation in late 2000. In the interim, the VA operates a

primary care clinic within David Grant Medical Center and purchases inpatient care on the military wards.

Nationally, the Air Force is an active participant on the DOD/VA Executive Council. One of the primary purposes of the Council is to facilitate expanded participation by the two Departments and their medical treatment facilities in direct sharing and TRICARE initiatives. One of the major projects overseen by the Council is the development of jointly adopted, evidence-based Clinical Practice Guidelines (CPGs). The group worked to select guidelines that will enhance continuity of care, reduce variability and facilitate cost-effective practices for both agencies. The CPT working group formulated the protocols, developed educational materials for providers, and is evaluating the new guidelines. Implementation of this program will be Service specific. Each clinical guideline will be deployed with complementary "tool kits" and corresponding metrics. The use of the same clinical guidelines helps ensure continuity in the care provided as DOD and VA beneficiaries move between the facilities in the two Agencies.

Another project which the Air Force actively supports is the Government Computerized Patient Record. Our goal is one secure electronic patient record, which is readily available whenever, and wherever a patient is treated, both while on active duty and after retirement.

A single discharge physical was another project overseen by the Council. By removing the redundancy of two separate discharge physicals, we will save money and time.

The newest initiative managed by the Council, based on a White House tasking, is the enhancement of patient safety programs. Building on the expertise within both Agencies as well as the civilian sector, processes are currently being reviewed and proposals developed relating to this critical area.

The Council has overseen a number of studies and reports in the last few years. Based on the recommendations in the studies, the Air Force has implemented reimbursement guidelines to assist our military treatment facilities in reviewing opportunities to partner with the VA. The Air Force is currently working with DOD and the VA to establish a new subcommittee to the Council, the DOD/VA Health Care

Sharing Committee. This will enhance direct sharing and TRICARE contracting relationships and would assist in resolving issues that detract from our partnering efforts.

Cooperation is also occurring in the area of drug purchasing. The Federal Pharmacy Executive Steering Committee is composed of DOD and VA pharmacists, physicians and resource managers. By identifying joint pharmaceutical contracting initiatives, the DOD and VA can use combined purchasing power to leverage lower drug prices.

Since the mid 1990's, the number of Veterans Administration Medical Centers (VAMCs) participating as TRICARE network providers has grown to 81%. As with the non-government TRICARE contracted providers, challenges regarding reimbursement for VAMCs through the managed care support contractors have arisen. The VA is currently working with DOD and the contractors to resolve issues surrounding their participation as TRICARE network providers.

I do need to make clear that VA/DOD sharing or joint projects will not work at every Air Force base. If it is a win-win situation for both partners, then of course it makes sense. These arrangements provide an opportunity to save money for the taxpayer while increasing access to health care for the government beneficiary. We have found some instances where the VA was not the most cost effective option. If the VA is not a competitive player in the market, then an agreement would not be appropriate.

Barriers to sharing for the Air Force also include geographic concerns. There are no VAMCs close to eight Air Force bases. For instance, Grand Forks Air Force Base in North Dakota is more than a seventy mile drive to the closest VAMC. Weather restrictions combined with the driving distance make active sharing difficult at these locations. Another barrier includes concerns that have arisen about the role of direct sharing versus participation of the VA as part of the TRICARE network. This area is currently being reviewed by the Assistant Secretary of Defense (Health Affairs).

I believe that DOD medical contingency and readiness requirements drive a need for two separate systems to support the different missions of the two organizations. Readiness related activities must remain within DOD control. Resupply of pharmaceuticals and medical supplies for contingency operations, readiness training for Air Force medical personnel, and command and control are some examples. While there

remains a need for two systems, our existing partnering efforts are critical to meeting future peacetime health care needs. The right answer is an approach that continues to explore future opportunities by building on our strengths while recognizing the rapid changes in the U.S. health care environment. Both the DOD and VA systems have been responding to years of fiscal and budgetary constraints, a need to reinvent or reengineer within the federal sector, and technology-driven shifts to more outpatient-based services. Our joint ventures, sharing agreements, TRICARE managed care support contracts and joint DOD/VA projects have evolved to meet these needs. Air Force facilities will continue to develop partnering programs with their VAMC counterparts to meet the future requirements of both our organizations.

In conclusion, I believe there are great benefits in VA/DOD health care sharing. However, the arrangements must be carefully evaluated to confirm the benefit before pushing forward. I support continued exploration of how we can capitalize on those areas in which joint efforts produce positive results for both Agencies. I thank you again for the opportunity to testify today and for your continued support of the Air Force Medical System.

Responses from Mr. Anthony Principi to questions posed by the Honorable Cliff Sterns

1. Question:

In responding to a question at the hearing, Mr. Backhus of the General Accounting Office stated that not each VA-DoD partnership is a "win-win" situation, and that there are opportunities in some cases to obtain care at less cost in the private sector. Shouldn't the touchstone for assessing a VA-DoD health resource sharing agreement be broader than that, to include its cost-effectiveness to the federal government (including, as appropriate, improved access to the beneficiaries), not simply the relative cost to the buyer of the service?

Answer:

The touchstone for assessing the success of the health resource sharing agreement between the VA and DoD should be based on providing a continuum of high quality health care to each agencies beneficiaries in the most cost effective way possible. VA and DoD should assess the cost effectiveness of providing that care, not only through a partnership between the two agencies, but also through a partnership with the private sector as well.

2. Question:

You propose that VA and DoD create a joint staff to identify opportunities for greater sharing. Are there precedents for such an arrangement? Do you see establishment of a joint staff as a starting point for the development of a partnership between these two health care systems or as a logical extension of other actions which would have to precede that step?

Answer:

I am not aware of any precedents for a joint health care policy staff in the federal government. The Goldwater Nichols Act mandated joint staffing in the operational components of the military services and could serve as a model for a VA-DoD health care joint policy staff. I do not see the establishment of a joint staff as either a starting point for such a partnership or as a logical extension of other actions, but rather, one of many steps that should be taken to build a strong partnership between VA and DoD and insure sound policy decisions in the conduct of health care delivery to their beneficiaries.

3. Question:

You propose that in certain circumstances VA facilities could be considered the equivalent of a military treatment facility. Would you elaborate on that idea?

Answer:

Designating VA Medical Centers (VAMC) as Military Treatment Facilities (MTF) would afford greater access to more treatment for Tricare beneficiaries in a more cost-effective manner. Also, the VA, with a declining veteran population, would have an increase in potential patients. In order to make this a reality, the designation of VAMC's as MTF's should occur before the next round of Tricare contracts are executed.

4. Question:

Your testimony suggests that, regardless of the changes that have occurred in the health systems, there could be considerably more sharing going on than actually occurs. There exists very broad legal authority, and broad policy to encourage sharing. What do you think is missing? Is it leadership at the top or something else?

Answer:

I believe leadership at the very top, starting with the White House, Director of OMB and the Secretaries of each Department, is required to breakdown the institutional barriers separating these two Departments. Unless someone in a position of authority over both Departments directs action and holds people accountable, sharing will continue to be incremental and marginal. The beneficiaries and taxpayers will be the losers and the current systems the winners.

Post-Hearing Question
Concerning the May 17, 2000, Hearing

for
Dr. Thomas L. Garthwaite
Deputy Under Secretary for Health
Veterans Health Administration, Department of Veterans Affairs

from
The Honorable Cliff Stearns
Chairman, Subcommittee on Health
Committee on Veterans' Affairs
U. S. House of Representatives

Question: Dr. Garthwaite, you were asked at the hearing to comment hypothetically from the perspective of a VA facility director whether you would be hesitant to invest resources in developing a new sharing agreement with a military treatment facility knowing that DoD was reassessing existing sharing agreements. You responded to the effect that you would be encouraged based on the view that existing "concerns" were "being addressed forthrightly" and on the belief that "we can make significant progress quickly". Please update the Subcommittee on specific progress made since the hearing and, if no progress has been made to date, on the specific steps you have taken to advance such progress.

Answer: I believe that DoD is making a sincere attempt to address existing concerns. The VA/DoD Executive Council, at its May 24, 2000 meeting, agreed to reactivate the VA/DoD Healthcare Financial Management Committee. One of the guiding principles of this Committee is that "VHA and the Military Health System are sister Federal programs with similar missions of providing health care to military personnel, veterans, and dependents. As such, the Departments should see each other as partners in a long-term relationship, and not simply as another entity in the health care marketplace . . ." The Committee addresses budgeting and, resource management problems including billing and reimbursement issues.

The Executive Council, at its May 24, 2000 meeting, also agreed to establish a VA-DoD Healthcare Sharing Committee, which will assist in implementing DoD's Health Affairs Policy Memorandum, "Use of Health Care Facilities of the Department of Veterans Affairs under TRICARE and the Supplement Health Care Program." (Copy attached). The intent of the memorandum is to clarify the role of VA-DoD sharing within the military health care system. The Committee will address other programmatic concerns as well.

DoD Health Affairs has stated that it intends to fully reimburse VA Medical Centers for services provided under VA/DoD agreements that were converted to TRICARE billing. VA and DoD are setting up a program to identify underpaid claims and establish a method for payment.

Attachment

THE ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, D. C. 20301-1200

HEALTH AFFAIRS

MAY 16 2000

MEMORANDUM FOR SECRETARY OF THE ARMY
SECRETARY OF THE NAVY
SECRETARY OF THE AIR FORCE

SUBJECT: Use of Health Care Facilities of the Department of Veterans Affairs under TRICARE and the Supplemental Health Care Program

This memorandum is to reaffirm and clarify DoD policy on the use of health care facilities of the Department of Veterans Affairs (VA) under TRICARE Prime, TRICARE Extra, and TRICARE Standard options and under the Supplemental Health Care Program (SHCP). It is DoD policy to include VA facilities under both TRICARE and the SHCP in all instances where it is to the mutual benefit of both Departments under the established DoD policies and procedures for these health care delivery programs. The evolving Military Health System health care delivery strategy, focused on developing an integrated health care delivery system, with standardized processes and simplified network development has resulted in some misunderstandings for Military Treatment Facilities (MTFs), managed care support (MCS) contractors and VA facilities, particularly with regard to previously established arrangements with VA. The purpose of this memorandum is to correct any misunderstandings by specifically restating current DoD policies with regard to obtaining health care services from VA facilities.

Inclusion of VA facilities as providers under the Supplemental Health Care Program.

The OASD(HA) Policy Memorandum, "Policy for Inclusion of Department of Veterans Affairs Facilities as TRICARE Network Providers," May 14, 1999, requiring that TRICARE Prime network agreements be made by TRICARE contractors, and not by MTFs, was not addressing agreements to include VA facilities under the Supplemental Health Care Program. The May 14, 1999, policy memorandum did not prohibit agreements between VA facilities and MTFs for purposes of the SHCP. Such agreements continue to be authorized. As outlined in OASD(HA) Policy 96-005, "Policy on Use of Supplemental Care Funds by the Military Departments," October 18, 1995, the SHCP is primarily to pay for care provided by non-MTF providers to active duty members. These funds may also be used under very limited circumstances for care of a non-active duty patient ordered by an MTF provider from a non-MTF source to support the MTF provider in maintaining full clinical responsibility for the episode of care.

For care provided by the VA under a local, regional or national Memoranda of Understanding (MOU) for the SHCP, the claim shall be submitted directly to the MTF involved or other DoD entities specified in the applicable MOU. The MTF or other DoD entity shall process and pay the claim in accordance with the MOU. Any such claims for which proper payment has not yet been made shall be paid promptly. The TRICARE regional managed care support contractor is responsible for processing and paying for any SHCP services not covered by existing local MOUs. In accordance with TRICARE Operations Manual (OPM) Part One, Chapter 1 and Part Three, Chapters 9 and 10, claims for services provided under current MOU between the Department of Defense (including the Army, Air Force, and Navy/Marine Corps facilities) and the Department of VA are not processed as other SHCP claims. For care provided by VA facilities not under a MOU, the VA facility will submit the claim to the managed care

support contractor, together with the same certification currently used for TRICARE claims to document that the service provided was not included in the MOU.

Inclusion of VA facilities under national DoD-VA agreements.

To further promote the use of VA facilities, authority to enter into national sharing agreements with VA was delegated to the Military Departments on September 24, 1999, to provide health care services for members of both the active and reserve components. Active duty care for Spinal Cord Injury, Traumatic Brain Injury, and Blind Rehabilitation will be provided by VA at negotiated rates under these national sharing agreements. Additionally, emphasis on identifying and expeditiously including VA facilities in referral and management of catastrophic injuries is critical for both high quality health care and for patient management for which the VA will be ultimately responsible. These national agreements continue to be authorized under the Supplemental Health Care Program. VA facilities providing health care services under these agreements shall be reimbursed at the rates specified in those agreements regardless of whether payment is made by a local MTF, a Military Department, or an MCS contractor.

Inclusion of VA facilities as TRICARE Prime network providers.

As stated in HA Policy Memorandum, "Policy for Inclusion of Department of Veterans Affairs Facilities as TRICARE Network Providers," May 14, 1999, DoD policy encourages inclusion of all VA facilities in TRICARE Prime provider networks. In accordance with the June 1995 Memorandum of Understanding between DoD and VA (which remains in effect), this policy is carried out through agreements between VA facilities and the TRICARE regional MCS contractor. The organization of TRICARE Prime provider networks, designated as a contractor responsibility in TRICARE contracts, must remain under a unified management structure for the Military Health System to achieve its goal of a cost-effective, integrated managed care system and to comply with contractual obligations of the MCS contracts. With the exception of local, regional or national DoD-VA MOUs discussed above for the SHCP, separate agreements, which do not include the TRICARE contractor as a party, to establish non-military facility sources of care for TRICARE Prime enrollees and TRICARE Extra patients are not authorized.

Improving future procedures for the DoD-VA Sharing Program

Given the significant changes with TRICARE implementation and our commitment to optimally use all federal health care facilities, DoD together with VA will initiate a review of all local MOUs and sharing agreements to determine the most appropriate cooperative arrangements for both departments in the future.

The VA/DoD Executive Council has been established to facilitate and develop mutually beneficial partnerships between the Departments to coordinate the provision of health care and optimally use federal resources. The Executive Council established the VA/DoD Healthcare Financial Management Committee (HFMC) to resolve financial and claims issues that cannot be solved at local or intermediate organizational levels. I will recommend that the Executive Council approve a new VA/DoD Partnering Workgroup to be established with representatives from the Services, OASD(HA) and VA. This workgroup will oversee implementation and

monitoring of this policy and will address additional issues to improve the partnership between the departments. My point of contact for the VA-DoD sharing program is Mr. Ken Cox, (703) 681-1757.

Dr. Sue Bailey

cc:
Surgeon General of the Army
Surgeon General of the Navy
Surgeon General of the Air Force
Executive Director, TRICARE Management Activity

Committee on Veterans Affairs
Hearing on May 17, 2000
Questions for the Record
Ms. Gwendolyn Brown
Deputy Assistant Secretary of Defense for
Health Budgets and Financial Policy
Office of Assistant Secretary of Defense (Health Affairs)
from Honorable Cliff Stearns
Chairman
Subcommittee on Health

1. On May 16, 2000, the day preceding our hearing, Assistant Secretary of Defense for Health Affairs Dr. Sue Bailey issued a policy memorandum entitled "Use of Healthcare Facilities of the Department of Veterans Affairs Under TRICARE and the Supplemental Health Care Program (SHCP)". (Please furnish a copy of the signed memorandum for the record.) The stated purpose of the memorandum is to correct misunderstandings regarding obtaining health care services from VA facilities. Please respond to the following questions regarding that memorandum:
   (a) The memorandum is silent with respect to VA-DoD agreements in TRICARE Prime Remote (TPR) areas under which VA medical centers had provided medical services to active duty personnel located in these noncatchment areas. What is the status of those VA-DoD agreements (which were in effect prior to October 1, 1999) in TPR areas?

   Answer: In TRICARE Prime Remote (TPR) areas, that is areas in which there are no military medical facilities within fifty miles of active duty personnel, all care is provided through the Managed Care Support Contractors' networks, where they exist. Where they do not exist, active duty personnel may use non-participating providers for care. In that regard, as the majority of VA facilities are network providers, they would treat active duty personnel referred to them through the network. In accordance with its agreement, the VA facility would submit its claim to the contractor for payment at the network agreed upon rate. In those areas where there are no TRICARE network providers, VA facilities that treat active duty personnel would be paid in accordance with the sharing agreement that is in effect. All agreements are being scheduled for review and those that have been replaced by network agreements will be terminated or modified, as appropriate.

   (b) The memorandum is unclear regarding (1) expansion of any existing VA-MTF agreement to provide for the VA medical center to furnish medical or other services not currently provided for under such an agreement or (2) development and approval of new VA-MTF sharing agreements. On the one hand, the memorandum states that prior policy was not intended to prohibit VA-MTF sharing; on the other hand, it states that DoD and VA will initiate a review "to determine the most appropriate cooperative arrangements for both departments in the future." The latter statement could certainly be construed to foreclose any expansion of sharing activity pending completion of that "review" and determination.

What is the policy? Rather than encouraging expanded sharing, is there not a likelihood that this ambiguity will create an additional disincentive or perceived barrier to pursuit of any new sharing activity?

Answer: As has always been its policy, DoD encourages the expansion of sharing wherever it is beneficial to the Department. If new sharing opportunities emerge, there is nothing in the DoD policy that would prohibit, or even discourage, the development of a new agreement within the policy guidelines. The effort to determine the most appropriate cooperative arrangements for both departments in the future, speaks to both the GAO report, which recommended such a reassessment, and VA/DoD ongoing reviews of their respective health care delivery modalities. Many past agreements have been unused because they have not kept up with the changes in our business practices. A review of all agreements would identify those that have not been used and may result in revision or modification that would make the agreement usable. The issue is not *whether* to have VA-DoD sharing; it is *how* to have VA-DoD sharing. DoD and DVA agree that sharing for CHAMPUS-covered services will be accomplished through participation by VA facilities in the TRICARE contractor's provider network.

(c) The memorandum calls for military treatment facilities or other DoD facilities to pay claims as provided for under applicable MOU's. Have the services budgeted funds to pay for services provided for under these agreements in FY 2000? Do current Health Affairs' policies provide incentives for MTFs to refer patients to VA medical facilities opposed to being treated in non-VA facilities and paid for by TRICARE contractors? Are the military services planning to issue clear and consistent guidance on this question?

Answer: The Services medical budgets in FY 2000 contain funding for the costs of care under these agreements. The Department supports the relationship with the VA and efforts to foster optimum use of all federal health care facilities. As stated in its testimony, DoD and VA will initiate a joint review of all local MOUs and sharing agreements to determine the most appropriate cooperative arrangement for both departments in the future. The Military Departments have been instructed to issue guidance to their MTFs on the use and establishment of resource sharing agreements.

(d) The memorandum states that a May 14, 1999 policy memorandum "was not addressing...(and) did not prohibit agreements between VA facilities and MTFs for purposes of the Supplemental Health Care Program. (Emphasis added). Such agreements continue to be authorized." Since the term Supplemental Health Care Program is not defined in the memorandum, it is not clear to us precisely what the policy means. Are there agreements between VA facilities and MTFs other than agreements for purposes of the Supplemental Health Care Program"? If so, what are they? Are such agreements not authorized? If not, what does the addition of the qualifying phrase "for purposes of the Supplemental Health Care Program" mean?

Answer: By law, military health care services are authorized to be provided to eligible beneficiaries in three ways. The first way is through the military treatment facilities, also

referred to as the direct care system. Second, since the direct care system is not sized or staffed to provide all needed health care services, DoD is authorized to contract for health care services from non-DoD health care sources with reimbursement to providers under Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), now referred to as TRICARE. Third, under the Supplemental Care Program, DoD may use funds appropriated to the military departments to pay for health care from non-governmental sources for active duty members (who are not covered by CHAMPUS). Rules and procedures for the Supplemental Care Program are addressed in other DoD policy issuances.

(e) Legal Counsel with the TRICARE Management Activity (TMA) expressed the view last that VA-MTF sharing agreements covering services included in a TRICARE contract create a competing network. Although that view reportedly does not reflect DoD policy, this memorandum does not specifically address or call for a retraction of the prior TMA position. Has TMA retracted its position? Has it notified management support contractors that VA-MTF sharing agreements are lawful?

Answer: We have clarified that the issue of competing networks relates to care covered by CHAMPUS, not care covered by the Supplemental Care Program. For care covered by CHAMPUS, DoD favors full incorporation of VA facilities in the provider networks of TRICARE contractors.

(f) In light of the multiple ambiguities in the policy memorandum, and the importance that the goal of this policy - to clarify - will the Department issue further clarifying guidance on these important issues?

Answer: The Department does not view the policy memorandum as being ambiguous. The Department saw a need to add specificity to previous policy and, together with senior staff representatives of the Veterans Health Administration (VHA), crafted the most recent memorandum to ensure clarity of policy. As future requirements dictate, the Department in consultation with the VHA, will update its policy appropriately.

DoD's testimony at the May 17, 2000 hearing acknowledged with respect to VA provision of services to DoD beneficiaries under TRICARE contracts that DoD has "identified that some VA facilities are experiencing problems with claims payment." DoD's representative stated in her formal testimony that "(o)nce we have the (necessary claims) data, our contracting staff will expeditiously resolve the problem". GAO's May 17 report on VA-DoD sharing noted that DoD had not described how or when it would resolve the issue. What is the total of VA claims (by fiscal year) which TRICARE had not reimbursed as of May 17, 2000? What is the status of efforts to resolve those claims? Given that the failure to resolve substantial outstanding claims could become a disincentive to future sharing, what efforts has DoD taken to make resolution of this issue a priority?

Answer: DoD did acknowledge that it had recently been made aware that some VA facilities were encountering difficulty in receiving the proper payment for services provided under sharing

agreements. Those problems were attributable to unclear guidance on responsibility for payment. DoD committed to VA that it would rectify any incorrect payments upon receiving the necessary information from VA on these cases. The number of claims is unknown. As these agreements are, in most cases local-level agreements, the Department does not maintain central records on the status of any claims. It would depend on VA for that information. VA has agreed to query its facilities and provide DoD with an accounting. When that happens, reconciliation and payment can take place. With respect to issue resolution, language has been incorporated into the recent policy clarification memorandum to ensure that the parties responsible for payment are known.

The Department's testimony states that "sharing is as important now as it's ever been since 1982" and that you have an agenda for sharing that works", what is that agenda and exactly what role does sharing have in meeting DoD's health care goals?

Answer: The agenda is to collaborate in all areas of mutual interest and benefit. As has been stated previously, DoD and VA are both adapting to substantial changes in requirements imposed on their systems brought about by respective environments while preserving the integrity if their separate missions. Both systems face challenges in confronting major reductions in available resources. For those reasons we have been working closely together to ensure that we get the most out of our combined resources. One outcome of VA's participation in TRICARE is that it provides more sources of care and, this, in turn, helps DoD meets it goal of greater beneficiary access to care.

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