BY THE COMPTROLLER GENERAL

Report To The Congress

OF THE UNITED STATES

Legislation Needed To Encourage Better Use Of Federal Medical Resources And Remove Obstacles To Interagency Sharing

The Federal Government can make much better use of its health care delivery resources through interagency sharing. However, legislative and administrative obstacles prevent the effective use of these resources. In this report several recommendations to overcome these obstacles are made to the Congress, the Office of Management and Budget, and the agencies primarily responsible for the delivery of Federal direct health care--the Departments of Defense and Health, Education, and Welfare and the Veterans Administration.

The agencies' comments on the recommendations varied considerably, showing a need for

--congressional action to enact legislation to provide the impetus for the development of an effective Federal medical resources sharing program and

--the establishment of a uniform executive branch policy regarding interagency sharing.

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COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

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To the President of the Senate and the
Speaker of the House of Representatives

This report discusses actions needed by the Congress and the executive branch to make better use of Federal medical resources and remove obstacles to interagency sharing.

Our review was made at the request of the Chairman, House Committee on Appropriations, and pursuant to the Budget and Accounting Act, 1921 (31 U.S.C. 53), and the Accounting and Auditing Act of 1950 (31 U.S.C. 67).

We are sending copies of this report to the Director, Office of Management and Budget; the Secretaries of Defense and Health, Education, and Welfare; and the Administrator of Veterans Affairs.

ACTING Comptroller General
of the United States

COMPTROLLER GENERAL'S
REPORT TO THE CONGRESS

LEGISLATION NEEDED TO ENCOURAGE BETTER USE OF FEDERAL MEDICAL RESOURCES AND REMOVE OBSTACLES TO INTERAGENCY SHARING

D I G E S T

The Congress has expressed its desire for greater sharing of the Nation's medical resources by enacting several laws to encourage regional cooperation in the health care community. However, Federal agencies' participation in regional health planning groups established as a result of these laws has, for the most part, been only advisory.

No interaction is required between Federal agencies responsible for the direct delivery of health care. Moreover, no laws clearly require Federal interagency sharing, although several permit Federal health facilities to share their capabilities with other agencies.

GAO studied the direct health care delivery activities of the Department of Defense (DOD), the Veterans Administration (VA), and the Department of Health, Education, and Welfare's (HEW's) Public Health Service to identify (1) opportunities for Federal health care providers to share their resources and (2) legislative, administrative, and other obstacles which preclude or inhibit sharing. Each is responsible for providing medical care to specified categories of beneficiaries.

The Office of Management and Budget works with the agencies to improve the planning and coordination of Federal health programs, most often through its annual budget reviews.

In fiscal year 1977, DOD, VA, and HEW collectively spent over $6 billion to provide medical care directly to eligible Federal beneficiaries and over $700 million for medical care provided to eligible beneficiaries in the non-Federal sector. Recently, representatives of the three agencies met to

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begin planning for increasing interagency sharing. An interagency Federal Health Resources Sharing Committee has been established. (See p. 10 and apps. II and III.)

Numerous opportunities for increased interagency sharing either were not considered as opportunities by the agencies involved, had been pursued but abandoned, or had been only partially successful. (See app. IV.)

In most instances the following obstacles precluded attempts by or discouraged local Federal officials from completing satisfactory interagency sharing arrangements.

--The absence of a specific legislative mandate for interagency sharing and a lack of adequate headquarters guidance on how to share. (See p. 11.)

--Restrictive agency regulations, policies, and procedures. (See p. 14.)

--Inconsistent and unequal methods for agencies to be reimbursed for services rendered to other agencies' beneficiaries. (See p. 23.)

Attempts to share, whether started at the local Federal hospital level (including clinics) or by an interagency group at the department level, such as the Federal Health Resources Sharing Committee, will be hindered by the same obstacles.

Existing legislation is subject to various interpretations and/or permits only certain types of resources to be shared. This makes it difficult for agencies to use such legislation to increase interagency sharing. Frequently Federal officials do not know what the specific groundrules are, and little substantive direction has been provided to local Federal hospitals concerning interagency sharing problems and questions.

Eliminating legislative and administrative obstacles and implementing a structured

Federal interagency sharing program would be advantageous to both the Federal Government and its health care beneficiaries.

A key factor is enacting legislation to direct interagency sharing whenever appropriate and encourage the establishment of uniform Government-wide implementing procedures. Such legislation should encourage individual initiative without affecting any Federal agency's organizational or command structures. It should also give increased management options to local Federal medical officials to make the best use of the Nation's medical resources.

RECOMMENDATIONS TO AGENCIES

The Secretaries of Defense and Health, Education, and Welfare and the Administrator of Veterans Affairs should jointly direct the Federal Health Resources Sharing Committee to expeditiously seek workable solutions to the administrative obstacles within each agency which impede sharing, and report individually on an annual basis to the congressional appropriations committees on the progress being made in implementing an effective sharing program. (See p. 30.)

The Director, Office of Management and Budget, should establish a management group within the existing Office of Management and Budget organizational structure to work with DOD, HEW, and VA to better coordinate the development of an effective Federal sharing program. The group should work closely with the Federal Health Resources Sharing Committee and with the Office of Management and Budget officials responsible for reviewing budget requests for Federal health care delivery activities in order to foster increased interagency sharing. (See p. 30.)

RECOMMENDATIONS TO THE CONGRESS

The Congress should enact legislation to establish a greatly expanded and cost-effective interagency sharing program. Specifically this legislation should:

--Establish a Federal policy that directs interagency sharing when appropriate.

--Authorize each Federal direct health care provider to accept all categories of eligible beneficiaries on a referral basis when advantageous to the Government and care of primary beneficiaries would not be adversely affected.

--Eliminate all restrictions on the types of medical services which can be shared.

--Authorize Federal field hospital managers to enter into sharing arrangements, subject to headquarters veto only if judged not in the best interests of the Government.

--Authorize expansion of services as necessary to use Federal medical resources in the most cost-effective manner.

--Establish a policy requiring full use of available nearby Federal medical resources before using civilian or distant Federal medical resources.

--Authorize the establishment of a method of reimbursement under which the providing Federal hospital would receive any revenues received to offset any expenses incurred.

--Assign to the Office of Management and Budget the responsibility to (1) coordinate the implementation of an effective interagency Federal medical resources sharing program and (2) report annually to the Congress concerning the progress being made toward increased sharing of these resources. (See p. 30.)

AGENCY COMMENTS

DOD and HEW generally agreed with GAO's conclusions and recommendations. VA did not. The Office of Management and Budget did not take a position on the legislative recommendations, but disagreed with GAO's recommendation regarding the designation of a group to work

with the Federal agencies to coordinate the development of an effective interagency sharing program.

GAO's evaluation of the agencies' comments is on pages 31 through 38.

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Contents

		Page
DIGEST		i
CHAPTER		
1	INTRODUCTION	1
	Major Federal health care delivery systems	1
	Legislative authorities for sharing Federal medical resources	3
	OMB oversight of Federal health care delivery activities	8
2	OBSTACLES TO SHARING	10
	Lack of specific legislative authority and adequate headquarters guidance	11
	Restrictive regulations, policies, and procedures	14
	Inconsistent and unequal reimbursement methods	23
3	CONCLUSIONS, RECOMMENDATIONS, AND AGENCY COMMENTS	28
	Conclusions	28
	Recommendations to DOD, HEW, and VA	30
	Recommendations to OMB	30
	Recommendations to the Congress	30
	Evaluation of agency comments	31
4	SCOPE OF REVIEW	39
	Hospitals and clinics reviewed	39
APPENDIX		
I	Request letter, dated January 10, 1977, from the Chairman, House Committee on Appropriations	42
II	Prior studies indicate continuous concern over management and proper use of Federal medical resources	44

APPENDIX		Page
III	Federal agencies' efforts to better use medical resources	58
IV	Case studies of selected opportunities--and related obstacles--to interagency sharing	64
V	Proposed legislation for assuring the development of policies and procedures to make more efficient and effective use of existing Federal medical resources	147
VI	Letter dated April 5, 1978, from DOD	152
VII	Letter dated April 17, 1978, from HEW	159
VIII	Letter dated April 18, 1978, from VA	163
IX	Letter dated March 21, 1978, from OMB	169
X	Principal officials responsible for administering activities discussed in this report	170

ABBREVIATIONS

CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CHAMPVA	Civilian Health and Medical Program of the Veterans Administration
DOD	Department of Defense
GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare
OMB	Office of Management and Budget
PHS	Public Health Service
VA	Veterans Administration

CHAPTER 1

INTRODUCTION

Over the years, increasing concern has been expressed in the Congress and elsewhere over the rapidly increasing costs of medical care in the Nation. As in the private sector, Federal agencies' costs to provide health care directly to eligible beneficiaries have continued to rise, and substantial efforts have been made to explore ways of reducing these costs without adversely affecting the quality of care.

The Chairman, House Appropriations Committee, in January 1977 asked us to identify (1) opportunities for Federal health care providers to share their resources and (2) legislative, administrative, and other obstacles which may preclude sharing. The Chairman stated that the Committee was particularly interested in our recommendations to overcome these obstacles.

In response we visited or contacted officials at 50 Federal medical facilities in several areas of the United States and at the headquarters offices of the Federal agencies having major responsibilities for providing health care directly to beneficiaries. Because we focused on identifying obstacles to sharing and ways to overcome them, we did not attempt to identify all sharing opportunities which may exist in the geographic areas reviewed. The scope of our review is more fully discussed in chapter 4.

MAJOR FEDERAL HEALTH CARE DELIVERY SYSTEMS

The Department of Defense (DOD), the Veterans Administration (VA), and the Department of Health, Education, and Welfare (HEW) have the major responsibilities for providing health care directly to eligible Federal beneficiaries. 1/ Although we reviewed only selected direct health care activities of these agencies, our comments and recommendations should apply to all Federal direct health care providers.

1/We concentrated on HEW's Public Health Service hospital system (including clinics). However, HEW's Indian Health Service has significant responsibilities for meeting the health needs of Indians. Other Federal agencies also provide health care to specified segments of the population. For example, the Justice Department's Bureau of Prisons provides health care--with the assistance of Public Health Service physicians--to prison inmates.

DOD health care beneficiaries include active duty military members and, when space, facilities, and staff are available, their dependents, retirees, and dependents of retired and deceased military members. DOD's health care delivery system is composed of three separate systems administered by the Surgeons General of the Army, Navy, and Air Force. VA health care beneficiaries include veterans with service-connected disabilities, those with non-service-connected disabilities who meet other eligibility criteria, and dependents and survivors of certain veterans. HEW's Public Health Service (PHS) hospital system cares for several categories of beneficiaries, including American seamen and active duty members of the Coast Guard and PHS. The following table illustrates the magnitude of these agencies' medical operations within the continental United States.

Hospital and clinic system	Number of Hospitals	Number of Clinics	Estimated expenditures for hospitals and clinics (FY 1977)	Total FY 1977 Hospital admissions	Total FY 1977 Outpatient visits
			(000,000 omitted)	(000 omitted)	
DOD	129	203	$2,500	848	48,140
VA	171	219	3,663	1,270	14,675
PHS	9	26	115	34	1,733
Total	309	448	$6,278	2,152	64,548

In addition, the Congress has appropriated substantial amounts to the agencies to pay for medical care for their beneficiaries at other than their own facilities. For example, in fiscal year 1977, the Congress appropriated about $566 million for DOD to provide for medical services to beneficiaries under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) 1/ and about $28 million for VA to provide for services to certain beneficiaries under

1/CHAMPUS provides medical care from civilian sources for dependents of active members, retirees and their dependents, and the dependents of deceased members. "Uniformed services" include the Army, Navy, Air Force, Marine Corps, Coast Guard, and commissioned corps of PHS and the National Oceanic and Atmospheric Administration.

the Civilian Health and Medical Program of the Veterans Administration (CHAMPVA). 1/ In addition, DOD, VA and PHS contract with civilian facilities for hospital services. In fiscal year 1977 these agencies expected to spend about $128 million for such services.

LEGISLATIVE AUTHORITIES FOR SHARING FEDERAL MEDICAL RESOURCES

Congressional desire for greater sharing was demonstrated in the Heart Disease, Cancer, and Stroke Amendments of 1965 (42 U.S.C. 299-299j) and the Comprehensive Health Planning and Public Health Service Amendments of 1966 (42 U.S.C. 246). The purpose of the former legislation was to improve the level of health care in the Nation by increasing regional cooperation. The Comprehensive Health Planning and Public Health Service Amendments of 1966 authorized the creation of organizations to encourage cooperation between governmental or nongovernmental agencies, organizations, and groups concerned with health services, facilities, or manpower.

The most recent major legislation containing congressional intent concerning sharing was contained in the National Health Planning and Resources Development Act of 1974 (Public Law 93-641, 42 U.S.C. 300 et seq.). This legislation requires non-Federal hospitals to coordinate and plan the use of their medical resources in order to improve the quality of care and avoid duplication of resources. Although VA's participation in local health planning was provided for in the act and other Federal agencies were included in advisory capacities, no interaction between the VA, DOD, and HEW health systems was required.

Various laws permit Federal interagency sharing. No laws, however, clearly require interagency sharing. The authorities under which each agency reviewed is permitted to share, the authorities for each agency to secure services from non-Federal health providers, and Federal reimbursement arrangements are shown in the tables on the next three pages.

1/CHAMPVA provides care for the spouses and children of veterans who died or were totally disabled as a result of a service-connected disability.

Laws--and Reimbursement Rates--Authorizing Federal and Non-Federal Medical Resources To Be Shared With DOD (As of April 1978)

Provider		
VA	**PHS**	**Non-Federal**
31 U.S.C. 686 (Economy Act)--broad base for interagency sharing Reimbursement: actual cost using VA interagency rates ($138 per day--inpatient, $41 per visit--outpatient)	31 U.S.C. 686 (Economy Act)--broad base for interagency sharing Reimbursement: actual cost using PHS interagency rates ($142 per day--inpatient, $39 per visit--outpatient)	10 U.S.C. 2301 et seq.--DOD general contract authority Reimbursement: negotiable
38 U.S.C. 5053--sharing specialized medical resources only Reimbursement: full cost (including normal depreciation and amortization of equipment)	42 U.S.C. 254a--sharing specialized medical resources only Reimbursement: reasonable cost (including normal depreciation and amortization of equipment)	10 U.S.C. 1079, 1083, 1086--(CHAMPUS)--care for military retirees and dependents Reimbursement: 80 percent of provider's charges
38 U.S.C. 5003--facility and equipment sharing only Reimbursement: none required	10 U.S.C. 1074, 1076--active duty military, retirees, and dependents Reimbursement: PHS interagency rates	
10 U.S.C. 1074(b)--care for certain military retirees only Reimbursement: VA interagency rates		

Laws--and Reimbursement Rates--Authorizing Federal and Non-Federal Medical Resources To Be Shared With VA (As of April 1978)

Provider		
DOD	**PHS**	**Non-Federal**
31 U.S.C. 686 (Economy Act)--broad base for interagency sharing Reimbursement: actual cost using DOD interagency rates ($206 per day--inpatient, $20 per visit--outpatient)	31 U.S.C. 686 (Economy Act)--broad base for interagency sharing Reimbursement: actual cost using PHS interagency rates	38 U.S.C. 5053--sharing specialized medical resources only Reimbursement: full cost (including normal depreciation and amortization of equipment)
38 U.S.C. 5003--facility and equipment sharing only Reimbursement: none required	42 U.S.C. 254a--sharing specialized medical resources only Reimbursement: reasonable cost (including normal depreciation and amortization of equipment)	38 U.S.C. 213--general contract authority Reimbursement: negotiable
38 U.S.C. 616--care for veterans if authorized by appropriation or other act Reimbursement: DOD interagency rates	38 U.S.C. 616--care for veterans if authorized by appropriation or other act Reimbursement: PHS interagency rates	38 U.S.C. 628--contract for care where VA facilities are "not feasibly available" Reimbursement: negotiable
		38 U.S.C. 613--(CHAMPVA)--care for certain survivors and dependents of veterans Reimbursement: 75 percent of provider's charges

Laws--and Reimbursement Rates--Authorizing Federal and Non-Federal Resources To Be Shared With PHS (As of April 1978)

Provider		
DOD	VA	Non-Federal
31 U.S.C. 686 (Economy Act)--broad base for interagency sharing Reimbursement: actual cost using DOD interagency rates	31 U.S.C. 686 (Economy Act)--broad base for interagency sharing Reimbursement: actual cost using VA interagency rates	42 U.S.C. 254a--sharing specialized medical resources only Reimbursement: reasonable cost (including normal depreciation and amortization of equipment)
10 U.S.C. 1074, 1076--care of uniformed services beneficiaries Reimbursement: DOD interagency rates	38 U.S.C. 5053--sharing specialized medical resources only Reimbursement: full cost (including normal depreciation and amortization of equipment)	42 U.S.C. 249(e)--general contract authority Reimbursement: negotiable
	10 U.S.C. 1074(b)--care for certain retirees only Reimbursement: VA interagency rates	10 U.S.C. 1079, 1083, 1086--(CHAMPUS)--care for military retirees and dependents Reimbursement: 80 percent of provider's charges

The Economy Act, 31 U.S.C. 686, authorizes a Federal hospital 1/ to request the services of another Federal hospital. The act was designed to allow Federal agencies' resources to be used to capacity and avoid unnecessary duplication and overlap of activities. The statute is permissive, except for these limitations: (1) both hospitals must be Federal hospitals, (2) the supplier must be reimbursed on the basis of actual cost, and (3) the providing agency must be able to provide the service without increasing its resources. Patients can be admitted or transferred to hospitals other than those primarily charged with treating them, funds can be transferred from the requisitioning facility to the supplying facility, and staff from other agencies can be employed by the Federal hospital.

DOD

The Congress has expressed its desire for sharing of medical capabilities between military hospitals. Armed Forces hospitals are authorized to provide resources to other Armed Forces hospitals for treating active duty members and their dependents, certain former members and their dependents, and dependents of certain deceased former members. Transfers of funds between services is not required, and care for dependents and retirees is to be provided when space and other resources are available.

DOD hospitals are authorized to share facilities and equipment with VA under 38 U.S.C. 5003. In addition, they may provide medical services to certain veterans--under contract with VA--and emergency services to nonmilitary personnel. However, the Economy Act represents the only broad authority under which military hospitals may provide medical services to other agencies' beneficiaries. Unlike VA and PHS, DOD has no specific authorization to provide specialized medical services to other agencies' beneficiaries.

VA

VA, which administers the largest health care system under unified management in the Nation and uses a significant portion of the Nation's total health care resources, is authorized to share medical training resources and medical information resources. In addition to providing general

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1/Throughout this report the term "hospital" is used to describe both hospitals and clinics, whether or not the clinics are attached to the hospitals.

authority for VA to share its resources with Federal agencies under the Economy Act, the Congress has given VA specific authority (38 U.S.C. 5053) to share "specialized medical resources" with other hospitals and clinics (Federal, State, local) and medical schools.

Although fairly broad in scope, 38 U.S.C. 5053 does not give VA unlimited sharing authority. The most important limitation is that the statute covers only "specialized medical resources." These are defined as medical resources (whether equipment, space, or personnel) which, because of cost, limited availability, or unusual nature, either are unique in the medical community or can be fully used only through mutual use. Secondly, VA must be reimbursed the full cost of services. Finally, sharing arrangements negotiated under this authority may not decrease the quality of care provided eligible veterans. Beyond these restrictions, the statute is permissive. It does not restrict fund transfers, patient transfers, or staff mobility except insofar as these are indirectly affected by the above limitations.

VA facilities may also share equipment and facilities at no charge with DOD under 38 U.S.C. 5003. However, this statute does not provide for sharing medical services.

PHS

The Congress has expressed its desire for greater sharing involving PHS hospitals by enacting certain sharing legislation and during consideration of various bills. The principal concern has been to decrease needless duplication and to increase the quality of care provided in both PHS hospitals and non-PHS hospitals.

Like VA and DOD, PHS is authorized under the Economy Act to furnish facilities and services to other Federal agencies on a reimbursable basis. In addition, PHS is authorized by 42 U.S.C. 254a to share training and research resources, on a reimbursable basis, with medical schools and local agencies and to share specialized health resources, on a reimbursable basis, with hospitals and other health care facilities.

OMB OVERSIGHT OF FEDERAL HEALTH CARE DELIVERY ACTIVITIES

The Office of Management and Budget's (OMB's) responsibilities include:

--To help develop efficient coordinating mechanisms to implement Government activities and to expand interagency cooperation.

--To keep the President informed concerning the extent of Federal agencies' program coordination and whether appropriations are expended by agencies in the most economical manner with the least possible overlapping and duplication of effort.

To fulfill these responsibilities in regard to Federal health resources, OMB works with DOD, VA, and PHS to improve planning and coordination of Federal health care activities. For the most part, OMB's contacts with Federal agencies concerning health delivery occur during annual budget reviews. However, it has performed--with the assistance of these agencies--major studies of selected segments of the Federal health care delivery system. Also a recent revision to OMB Circular No. A-95 requires evidence of Federal agencies' coordination efforts with local health planning authorities before direct Federal medical construction projects or major equipment purchases will be approved.

In April 1977 the President signed the Reorganization Act of 1977 and directed the Director, OMB, to coordinate the examination of the entire Government structure to make it more responsive, efficient, and open. In a June 29, 1977, memorandum to executive agency heads, the President notified these officials that he had directed his Reorganization Project staff to begin a study of the organization and delivery of human services, which include health services. According to a Reorganization Project staff official, the study of the more than 100 Federal human services programs will be coordinated by a Human Resources group within the President's Reorganization Project and will draw upon the affected agencies for staff assistance. The group may study ways to streamline the Nation's Federal direct health care delivery systems.

CHAPTER 2

OBSTACLES TO SHARING

For nearly 30 years studies have pointed out the need for DOD, VA, and PHS to more effectively manage and operate their medical facilities. Several of these studies were conducted because of legislative requirements or because of congressional direction. Also we have, within the past several years, issued several reports on opportunities to make more appropriate use of Federal medical delivery capabilities by increasing either intraagency or interagency sharing. Many of the more important studies and our reports on this subject are discussed in appendix II.

Also the individual agencies reviewed have programs designed to make more efficient use of their own medical capabilities. For example, both DOD and VA have initiated programs to improve use of their health care resources within specified regions of the continental United States.

In mid-1977, at the invitation of the Assistant Secretary of Defense (Health Affairs), representatives of DOD, VA, and HEW met to initiate plans for increasing interagency sharing. As a result of this initiative, an interagency Federal Health Resource Sharing Committee was established. The Committee has been chartered by senior officials in each agency, organized itself, and met on several occasions. Two subcommittees have been established to formulate the basis for sharing decisions concerning cardiac catheterization and computerized tomography. Other subcommittees are being organized to address such issues as mobilization support and medical information systems. These subcommittees are expected to develop uniform standards to identify areas for potential sharing, and to present recommendations to the full Committee for sharing decisions. Appendix III discusses actions taken by the agencies to increase intraagency and interagency sharing.

We identified numerous additional opportunities for increased interagency sharing which were either (1) not considered as opportunities by the agencies involved, (2) pursued but then abandoned by the agencies, or (3) only partially successful. Appendix IV presents case studies of 20 of these opportunities and illustrates instances when the Government's costs of medical care for beneficiaries could be reduced without adversely affecting the care.

Reasons for the inabilities of officials at health facilities of one Federal agency to arrive at satisfactory sharing arrangements with those at facilities of a different agency varied considerably. In many instances the administrative difficulties encountered by these local officials apparently resulted from varied interpretations by the agencies concerning the extent of their sharing authority and the procedures to follow in arriving at sharing arrangements. In other instances local officials or their superiors were not inclined to consider sharing.

In most instances the following obstacles precluded attempts by or inhibited the efforts of local Federal officials to reach satisfactory interagency sharing arrangements.

--The absence of a specific legislative mandate for interagency sharing and a lack of adequate headquarters guidance on how to share.

--Restrictive agency regulations, policies, and procedures.

--Inconsistent and unequal reimbursement methods.

We believe that attempts to share, whether initiated at the local Federal hospital level or by an interagency group at the departmental level, such as the Federal Health Resources Sharing Committee, will be hindered by the same types of obstacles. The obstacles are discussed below.

LACK OF SPECIFIC LEGISLATIVE AUTHORITY AND ADEQUATE HEADQUARTERS GUIDANCE

Although numerous laws authorize (see pp. 4 to 6) beneficiaries from one Federal agency to be treated in another Federal agency's facility, none were explicit concerning what category of beneficiaries could be served. Of the laws, the Economy Act (31 U.S.C. 686) could probably best be used to share, but others, such as VA's sharing law (38 U.S.C. 5053) or PHS' sharing law (42 U.S.C. 254a) could also be used. However, these laws are interpreted differently by the agencies. Consequently, the extent of formal or informal sharing being conducted is minimal in terms of the total medical resources controlled by DOD, VA, and PHS. This condition prevails to some extent because the Congress has not enacted legislation which clearly specifies its expectations concerning interagency sharing.

The most recent major legislation containing congressional intent toward sharing the Nation's medical resources

was the National Health Planning and Resources Development Act of 1974 (Public Law 93-641). Although VA participation was included to some extent in local health planning capacities and other Federal agencies (including VA) were included in advisory capacities, no interaction between the VA, DOD, and PHS health systems was required. However, the House committee report on the bill that became Public Law 93-641 expressed the hope that a review of proposed Federal health activities "outside the jurisdiction of the committee" would be undertaken by those responsible for the activities. To date, no such review has taken place.

In July 1976 House Conference Report No. 94-1314 provided policy guidance to DOD--which currently has no specific legislative sharing authority--on interagency sharing. The report directed DOD to:

--Develop policies to make maximum and cost-effective use of existing Federal hospitals.

--Coordinate the planning of future bed capacity with other Federal health care representatives.

While this guidance helped DOD plan, for example, the size of new military hospitals, the only specific legislative authority by which DOD could share remained the broad authority in the Economy Act enacted in 1915. This act does not relate only to health care activities; rather it permits one Federal agency to request any type of service from another. In this manner the act allows Federal medical resources to be fully used and unnecessary duplication of resources to be avoided. In essence, the Congress told DOD to share with other Federal agencies but gave no additional legislative authority to supplement the Economy Act to accomplish this task. More importantly, the Congress did not provide (1) legislation to require interagency sharing when appropriate or (2) uniform guidance necessary for sharing.

Because of this lack of a legislative mandate, Federal agencies have been unable or unwilling to establish an effective Federal interagency medical sharing program. Generally, agency officials believe that their individual health care systems were established to serve specific beneficiaries and to provide care for another Federal agency's beneficiaries would adversely affect their abilities to perform their primary missions. As a consequence, interagency sharing has been given a low priority within Federal agencies and, as might be expected, there are currently no uniform policies, regulations, or procedures. Therefore, guidance

from the headquarters or command levels to hospitals or clinics attempting to enter into interagency sharing agreements generally lacks substantive direction.

In several examples a lack of guidance hindered sharing opportunities at the local hospital level. For example, in San Francisco, VA, through individual initiative, tried for almost 1-1/2 years to establish a sharing program with nearby DOD hospitals. (See app. IV, case study 7.) VA was particularly interested in obtaining services for its benficiaries at Letterman Army Medical Center. Letterman officials did not make any commitments to VA essentially because guidance on how to establish interagency sharing agreements was not available. Although Letterman requested guidance from the appropriate military medical coordinating staff in Washington, D.C., none was provided. Consequently, VA and Letterman did not exchange any services. VA could have saved about $100,000 annually if Letterman had provided services to meet part of VA's radiation therapy workload.

In another case, VA's Central Office did not respond to the Cheyenne VA Hospital on a proposed sharing agreement with the Warren Air Force Base Hospital. (See app. IV, case study 13.) Subsequently, no sharing agreement was ever finalized.

Also, in the Temple, Texas, area (see app. IV, case study 14) Darnall Army Hospital officials told VA that it was doubtful whether they were authorized to enter into a formal sharing agreement with VA. However, VA's authority (38 U.S.C. 5053) for entering into sharing agreements does provide that VA can buy services (although restricted to specialized medical resources) from, and/or sell specialized medical services to, other Federal hospitals.

The Army's Health Service Command, through which both Letterman and Darnall report, could not clarify the authorities and procedures for dealing with VA. The Chief of Plans and Operations said local Army officials do not pursue sharing opportunities with VA hospitals because they lack guidelines and procedures from DOD headquarters. The Chief of the Finance and Accounting Division said the Army did not have any regulation to correspond to VA's sharing authority, 38 U.S.C. 5053. Therefore, in his opinion, it was questionable whether Army hospital commanders are authorized to sign a VA sharing agreement. He also told us that it was uncertain whether the Economy Act authorized hospital commanders to negotiate or participate in sharing with VA.

The uncertainty and unresolved issues in these officials' statements typified those of most Federal agencies' headquarters officials with whom we discussed interagency sharing.

Because of the lack of uniform guidance, similar opportunities to share can have drastically different results. For example, on one hand, the Tucson VA Hospital had tried several times to enter into formal VA sharing agreements (38 U.S.C. 5053) with the Davis-Monthan Air Force Hospital. (See app. IV, case study 11.) Tucson VA's most recent effort to enter into a formal sharing agreement with Davis-Monthan took place in May 1974. Davis-Monthan officials decided that they weren't authorized to negotiate the type of agreement Tucson VA desired. They subsequently referred the proposed agreement to the Office of the Surgeon General, Strategic Air Command, to determine whether the proposed agreement was appropriate or required. A response, almost 3 months later, noted only that interagency rates were appropriate to be paid and did not address the type of agreement required. We could not determine why the local command had not followed up. No formal sharing agreement was finalized.

On the other hand, other VA and Air Force hospitals--Albuquerque VA Hospital and Kirtland Air Force Hospital--did enter into a formal VA sharing agreement similar to the one proposed by Tucson VA. (See app. IV, case study 12.) Air Force used the authority in its regulation concerning obtaining services to supplement its hospital's medical capabilities. Kirtland interpreted the regulation to include VA as a source for such services and did not receive any negative comments on the proposed agreement when it was submitted for review from higher authority--the Air Force Systems Command. Consequently, a sharing agreement was established, although further expansion into direct transfer and management of Air Force patients by VA may meet with certain regulatory restrictions.

RESTRICTIVE REGULATIONS, POLICIES, AND PROCEDURES

Several agency regulations, policies, and procedures, based on each agency's interpretation and implementation of existing legislation, inhibit interagency sharing. In several instances Federal hospitals could have shared services but refused because the treatment was not for emergency purposes or because beds, although available, had not been allocated in advance for use by another agency's beneficiaries.

We focused on DOD and VA regulations, policies, and procedures, since they are the largest Federal health care agencies. PHS' sharing authority, however, is restricted similarly to VA's.

DOD restrictions on treating VA beneficiaries

The most permissive interagency sharing authority which DOD could use to share its resources with other Federal agencies (e.g., VA) is the Economy Act. However, military regulations impose restrictions on providing services to VA beneficiaries under this authority.

For example, Army Regulation 40-3, section VIII, "Beneficiaries of Other Federal Agencies," paragraphs 4-29 and 4-30, place restrictions on VA beneficiaries being treated in Army facilities. Paragraph 4-29 covers eligibility of beneficiaries of other Federal agencies on a reimbursable basis at the expense of the referring agency under authority of the Economy Act. Paragraph 4-30, however, limits routine VA beneficiary care to Army facilities where beds have been allocated by prior agreement. Also admission to an Army facility within the continental United States in which bed allocations have not been made will be authorized only in emergencies. Navy and Air Force regulations also place similar restrictions on treating VA patients.

Also Army regulations regarding outpatient care for VA beneficiaries are not clear and are subject to interpretation. Army Regulation 40-3 states that outpatient care, other than in emergencies, must be authorized in advance. The Army Health Services Command's Chief of Patient Administration told us that this rule implies that it is permissible to furnish outpatient care to veterans, but it is only an implication subject to individual interpretation.

The chief also acknowledged that, at present, Army really has no specified mission to treat VA beneficiaries. For example, the "mission" argument was raised when VA requested radiation therapy from Madigan Army Medical Center. (See app. IV, case study 4.) Madigan responded by stating, in part, "* * * our next higher headquarters [Health Services Command] has not assigned us the mission of supporting the Veterans Administration in this matter." Consequently, VA was considering, at the time of our review, developing its own capability at an equipment cost alone of $500,000, although Madigan had the equipment.

This mission argument was raised in many of our discussions with DOD headquarters officials and in two other case

studies. (See app. IV, case studies 13 and 18.) In most instances these officials believed in the sharing concept but thought that their medical facilities' missions would not permit such a radical departure from their current manner of operation.

VA restrictions on treating DOD beneficiaries

The Economy Act also permits VA to share its medical resources with other Federal agencies (e.g., DOD). However, VA interprets the Economy Act's authority rather narrowly and inconsistently.

A VA Central Office official in the Office of Regionalization and Sharing said dependents of active duty and retired military personnel could be treated in a VA hospital, if a formalized sharing agreement between a military hospital and VA were negotiated as specified in the VA sharing law (38 U.S.C. 5053). These same individuals would not be treated, according to this official, if the VA hospital had negotiated an interagency agreement under the Economy Act.

Another Central Office official told us that the Economy Act generally gives other agencies access to VA medical supplies and equipment. It has traditionally been used for sharing things rather than people or services, and VA normally does not exchange health services under the Economy Act. The official further explained that there were only a few--10 at August 1976--field station interagency agreements between VA hospitals and other Federal agencies for VA to provide items and services. One of these agreements had been established between the San Diego VA and Naval Hospitals (see app. IV, case study 10) for VA to provide cardiac catheterization resources. This agreement, under the Economy Act's authority, specified that active duty and retired military and their dependents, both men and women, would be eligible for cardiac catheterization, which is inconsistent with what the Office of Regionalization and Sharing official told us.

To obtain clarification about VA's interpretation of the Economy Act, we wrote to the Administrator of Veterans Affairs in May 1977. We used the Tucson VA Hospital and other Federal agencies in the greater Tucson area as examples of informal sharing apparently being done under the Economy Act. (See app. IV, case study 11.) We asked whether VA hospitals are authorized to provide medical services to all beneficiaries of other Federal agencies under the act, as

Tucson VA was apparently doing. We also asked VA to specify authorities under which it believed it could provide medical services to other agencies' beneficiaries if it had determined that the Economy Act's authority could not be used to provide such services. VA answered, in part, that:

> "VA hospitals are authorized to provide medical services to all beneficiaries of other Federal agencies under the so called cross-servicing statute 31 U.S.C. 686 (Economy Act), as well as VA Regulations 2045 and 6046. The provision of such services at a VA Hospital is dependent upon present capacity to provide such services without interference with the primary function, which is to deliver health care to veterans. The determination of capacity or capability to provide the requested service is administrative and may be expected to constantly fluctuate in direct relationship to veterans' care needs. Another consideration inherent in cross-servicing under 31 U.S.C. 686 is the staffing and equipment which would be needed; there is no legal authority to engage in cross-servicing if additional staffing and equipment are required. (Emphasis added.)
>
> "Our consideration for the overall medical needs of the veteran and retired and active duty service personnel also caused us to review medical services for their dependents--women and children--whom VA is neither staffed nor equipped to serve. The VA contracts for such care. Accordingly, the VA is not in a position to "cross-service" such needs, and the questions of authority to cross-service and the basis for recovery of costs thereunder become essentially moot."

VA's answer failed to address the primary issue of cross-servicing dependents by declaring VA is neither staffed nor equipped to serve them. However, as we pointed out in our letter to the Administrator, Tucson VA was servicing active duty and retired military members and their dependents. In other instances VA hospitals were accepting these types of beneficiaries. In no instances were these services, according to the VA hospital officials involved, being provided to the detriment of VA's primary beneficiaries.

In addition, VA regulations restrict other Federal agencies' beneficiaries from receiving routine medical care. For example, VA's Manual relating to "Medical Care Furnished Other Federal Agencies" discusses treating DOD beneficiaries

in VA facilities. According to these regulations, active duty military personnel are approved for medical care if they require emergency hospital treatment or if they are potentially eligible as VA beneficiaries, because of forthcoming discharge from the Armed Forces. Outpatient treatment or examination in VA facilities must be authorized by the appropriate service departments. Retired members of the Armed Forces may receive hospital care or outpatient treatment on presentation of identification, when not otherwise eligible as a VA beneficiary. Dependents of active duty members will be given only emergency care. In addition, these regulations state that since VA does not have facilities for routine care and treatment of military dependents, such individuals will be transferred out of the VA system as soon as possible.

Restrictive VA sharing law

VA is permitted under its sharing law, 38 U.S.C. 5053, to share only specialized medical resources. The Chief Medical Director--VA's highest ranking medical official--determines what constitutes a specialized medical resource. Each resource considered for sharing is taken on its own merit in its particular geographical area. Therefore, a specialized medical resource in one area because of its cost, limited availability, or unusual nature may not be specialized and approved for sharing by the Chief Medical Director in another area.

Several VA hospital officials told us that the VA Central Office has been too restrictive in interpreting which resources may be shared under this authority and therefore sharing efforts are hindered. They believed that the law should be amended to allow sharing of every medical service, particularly between Federal facilities. Central Office officials also concluded that sharing restrictions need to be relaxed. They cited several examples when sharing proposals had been disapproved because of interpretations limiting types of services which may be shared. The disapproved proposals included sharing a therapeutic swimming pool, blood bank facility, psychiatric outpatient care, and outpatient alcoholic treatment.

A VA official told us that "most" proposed sharing agreements are discussed with field hospital officials by telephone before any formal submission to VA's Central Office. Consequently, it is difficult to tell how many proposals were turned down because of the need to meet the specialized resource requirement.

For example, a sharing opportunity in the Seattle/Tacoma area was prohibited, in part, by this requirement. (See app. IV, case study 1.) Military dependents were receiving psychiatric outpatient services under CHAMPUS, even though the American Lake VA Hospital could have treated many of them. Madigan Army Medical Center and American Lake VA Hospital attempted to negotiate a sharing agreement for VA to provide services, but were restricted for two reasons: (1) VA's Central Office determined that psychiatric outpatient services were nonspecialized and could not be shared and (2) military dependents were not eligible for care in VA hospitals.

VA has tried to remove the specialized restriction by recommending legislative changes. The Assistant Chief Medical Director for Policy and Planning told us that a legislative proposal had been sent to OMB for consideration. The proposal recommends deleting the existing 38 U.S.C. 5053 section and substituting an entirely new authorization, which would expand VA's ability to share. VA's proposal incorporated the following principles:

--The specialized requirement would be dropped entirely. Instead, sharing, including support services with any Federal or non-Federal hospital, would be permitted if such sharing is in the national interest.

--Reimbursement would be made on the basis of full cost for each separate service; all money would remain within VA, available for subsequent use.

--No services to veterans would be compromised.

Budgetary restrictions

Several sharing opportunities were unsuccessful because of VA's inability to budget for the care of another agency's beneficiaries. Consequently, equipment which could have been shared was not shared because the needed staffing was not in the budget.

For example, the Tampa VA Hospital's (see app. IV, case study 16) proposed sharing agreement to give MacDill Air Force Hospital radiological services was unsuccessful. Tampa VA sent a proposed formal sharing agreement to VA's Central Office for review and approval. Tampa VA explained that it could provide the services MacDill needed at an annual cost of $120,000 to be paid by Air Force. Tampa VA officials stated that this amount would be adequate to recruit two radiologists and a clerk-typist to handle the increased workload. No difficulty was expected in recruiting these radiologists.

VA's Central Office denied the request for several reasons, including the fact that VA had no budgetary authority to enter into a formal sharing agreement in which personnel would be recruited to serve nonveterans' needs. Consequently, Air Force expected to purchase these services from civilian providers at an estimated cost of $240,000, twice the amount VA would have charged.

This same obstacle was present in several other case studies. (See app. IV, case studies 4, 7, and 14.)

On another issue related to budgetary obstacles, DOD has certain alternative means of treating its own beneficiaries which favorably affect an individual military facility's health care budget but ultimately negatively affect any possible opportunities to share Federal medical resources. These alternative means involve using CHAMPUS and transferring patients to other DOD facilities using the domestic aeromedical evacuation system.1/

The alternative of using CHAMPUS creates a lack of incentive for local military hospital managers to use nearby Federal facilities. Under CHAMPUS, dependents of military personnel, military retirees and their dependents, and dependents of deceased military members may receive medical care in a civilian medical facility if the services needed are not available in their designated military medical system facility.

Generally, for inpatient treatment these patients must obtain a certificate stating that needed care is not available in any local military facility within a 40-mile radius. A similar certificate is not required for outpatient care. However, CHAMPUS is funded under a separate DOD appropriation from that financing the operation of the facility issuing the nonavailability certificate. Consequently, the facility issuing the certificate has no incentive to seek care for CHAMPUS patients in a nearby Federal facility because it is not held accountable for the funds needed to pay CHAMPUS providers. On the other hand, if beneficiaries were referred to a VA hospital, for example, there might be a charge which would come out of the local military hospital's budget.

1/Under this sytem, DOD airlifts patients under medical supervision in specially equipped aircraft to, between, and from its medical treatment facilities.

For example, during 1976 about $25,000 of nuclear medicine diagnostic procedures and $6,500 for electronencephalograms were procured under CHAMPUS when Seattle VA, Seattle PHS, and Madigan Army Medical Center could have provided such services. (See app. IV, case study 3.) In addition, some VA facilities were providing care to CHAMPUS beneficiaries, while in other cases DOD officials believed VA could not treat such beneficiaries. (See app. IV, case studies 1, 8, 14, and 20.)

A similar lack of incentive exists in some instances when DOD hospitals use the domestic aeromedical evacuation system. Air Force transports military beneficiaries from one military medical facility to another, and military departments using the service are not charged. Flights can be routed to pick up possibly just one patient at no expense to the requesting hospital. Therefore, DOD hospital officials might tend to rely upon this alternative rather than using nearby Federal facilities.

An unnecessary use of the aeromedical evacuation system similar to that identified in an earlier GAO report ("Questionable Use of the Domestic Aeromedical Evacuation System," MWD-75-45, Apr. 21, 1975) involved patients air evacuated by Homestead Air Force Hospital. During 1976 Homestead air evacuated 51 neurology inpatients to other DOD hospitals. During this period Miami VA could have provided the needed services. Eight other patients were air evacuated to military hospitals in Georgia, Mississippi, and Texas for nuclear medicine scans. Miami VA could have provided this service also. (See app. IV, case study 17.) A similar example involved Cutler Army Hospital and the West Roxbury and Bedford VA Hospitals in Massachusetts. (See app. IV, case study 20.)

Time-consuming review of proposed sharing agreements

VA Central Office procedures for reviewing and approving proposed formal sharing agreements submitted by local VA hospital officials are unnecessarily complex and time-consuming. VA hospital officials told us that the time taken by VA's Central Office to review these proposals inhibits interagency sharing.

VA headquarters officials told us that the Central Office approval process can take more than 60 days if difficulties are encountered. Sometimes agreements are returned for resubmission because of technicalities. For example, at the San Diego VA Hospital, a proposal was returned because the wrong contracting authority had been cited. (See app. IV,

case study 9.) In Seattle a proposed agreement took almost 10 months to obtain final approval. Also a Seattle VA physician told us that he was reluctant to share a newly developed highly specialized service because of administrative complexities in formulating and gaining approval of sharing agreements.

According to VA hospital officials, sharing would be facilitated by granting hospitals approval authority. One hospital director believed field officials should be authorized to approve contracts, agreements, or arrangements for sharing or exchanging medical resources. This authority would be subject to Central Office review and veto if the Central Office considered the agreement to not be in VA's or the Government's best interests. The local authority would, however, get things moving between participants without having to wait long periods for Central Office review.

Several DOD officials also mentioned VA's review procedures as constituting an obstacle to sharing. Officials at one Air Force hospital, for example, stated that VA officials take too long making up their minds about any type of agreement. They believed VA's procedures should be changed to allow local VA hospitals to negotiate and approve sharing arrangements.

Central Office officials, on the other hand, apparently believe review and approval should remain centralized. They told us the review period is supposed to take only 21 working days (about a month), but conceded that it could be longer if any of the several review control points--Supply Service, Professional Services, or General Counsel--had problems with the proposal. In 1974 authority was delegated to VA medical district directors to approve renewal sharing agreements where no changes had been made to the services being shared and costs had not increased by more than 10 percent.

A document used by VA's Office of Regionalization and Sharing in 1976 to brief VA officials on the VA sharing program contained the following excerpt which helps explain why Central Office reviews proposed sharing agreements:

> "A recommendation was made by a Medical District Director to decentralize the entire sharing program to the field. We do not believe the time has come to do this. We have less than 50 percent of our hospitals participating in the program. To those still uninitiated in 'sharing,' the program and what is intended is new territory. We do know from experience that even those VAH's [VA hospitals] that have

participated are prone to 'get off base' and require our assistance to stay within legal bounds."

INCONSISTENT AND UNEQUAL REIMBURSEMENT METHODS

A major obstacle to sharing involves reimbursement. Simply stated, no standard reimbursement mechanism exists between agencies, no clear policy is evident for allocating reimbursements back to providing hospitals, and reimbursement rates differ between agencies. Without adequate reimbursement hospital officials have no incentive for sharing and are reluctant to share.

Lack of standard reimbursement mechanism

VA uses two authorities--38 U.S.C. 5053 and the Economy Act, 31 U.S.C. 686--to share its medical resources with other Federal agencies.

Under 38 U.S.C. 5053, VA is required to obtain full reimbursement for any services provided and pay full costs for any services received. Full reimbursement means that VA must charge actual cost, including supplies used, and normal depreciation and amortization of equipment. Also VA may share only specialized medical resources at a level which will not reduce medical services to veterans. A formal sharing agreement is required, and services may be shared with Government, community, or private hospitals or clinics.

The Economy Act requires reimbursement based on actual cost. This reimbursement requirement has been satisfied by VA and other Federal agencies which use this authority by establishing, on an annual basis, daily inpatient and outpatient interagency rates, regardless of the service provided, based on total annual operating costs and the total annual inpatient and outpatient workloads. An interagency agreement, rather than a formal sharing agreement, is required under this statute.

Although both these authorities permit interagency sharing, the different reimbursement mechanisms restrict an active, continuing interchange of services. VA officials told us, for example, that from a budgetary standpoint there is a big incentive to provide services under the formal sharing authority (38 U.S.C. 5053) rather than under an interagency sharing agreement under the Economy Act.

Essentially, to furnish a "carrot" encouraging sharing, services provided under formal sharing agreement authority

could result in double payment to the local hospital since (1) the patient is counted in the workload statistics used to request funds from the Congress with subsequent allocations to the hospital and (2) VA allocates total reimbursement for services provided under sharing agreements back to the providing hospital. On the other hand, services performed under interagency agreements are reimbursed to VA's Central Office on the basis of the daily inpatient and outpatient rates, regardless of actual cost of the specific services provided. However, the reimbursement is not allocated back to the individual hospital to help offset expenses incurred.

We attempted to followup at VA's Central Office about why reimbursements were being allocated to hospitals under formal sharing agreements, but not under interagency arrangements. Central Office Budget Staff officials could not give us any administrative regulation or directive or cite legislation which required reimbursements from interagency agreements not to be reallocated to the providing hospital. The Director, Budget Staff, believes it is incorrect to consider other agencies' reimbursements to VA hospitals as not being allocated back to the local hospitals. The Director told us that the total reimbursements received in the Central Office-controlled Treasury account are used to offset the budgetary requests VA makes to the Congress for medical care. Consequently, the total reimbursements from all sources--estimated for budget purposes in fiscal year 1977 to be $33 million--are redistributed to all VA hospitals. However, the VA budget system does not provide the means to determine how much reimbursement goes to each individual hospital. A hospital not sharing any services could receive just as much in reimbursement allocations as one which shared extensively.

As a further followup, in our May 1977 letter to the Administrator of Veterans Affairs concerning reimbursement and other sharing problems between the Tucson VA Hospital and Davis-Monthan Air Force Hospital, we inquired about VA's reimbursement policies. For example, we asked what VA's current policy was regarding allocating reimbursements from other agencies for medical services received from VA hospitals back to the providing hospital. VA's formal reply was similar to that stated above:

> "Reimbursements for medical services rendered other Federal agencies for which payment is based on the inter-departmental rates published in the Federal Register is not returned to the hospital when earned, but is allocated to each facility in the initial recurring target allowance. These funds

are not identified separately, but the total funding allocations covers the inpatient and outpatient workloads assigned, including reimburseable workloads."

Because of VA's policy, VA hospital directors usually insist on using a formal (38 U.S.C. 5053) rather than an interagency (31 U.S.C. 686) sharing agreement. Under 38 U.S.C. 5053, which VA has used primarily for sharing with the private sector, hospitals are reimbursed. Under the Economy Act, however, reimbursements are not returned.

For example, at the Lexington, Kentucky, VA Hospital, a change in authority from a formal to an interagency sharing agreement resulted in a situation where services may not continue to be provided to two other Federal agencies unless Lexington VA recovers its costs. (See app. IV, case study 19.) One of these sharing agreements accounted for about $78,000 of the $92,000 of services provided by VA to other Federal agencies under this authority in fiscal year 1976. In addition, numerous other VA hospital officials told us they had no incentive to share services with other Federal agencies unless they were adequately reimbursed at the local level.

DOD's situation is not nearly as complex as VA's because DOD facilities have no sharing authority similar to VA's and sharing is done using interagency rates only. However, the same disincentive--lack of reimbursement--still exists.

DOD officials told us that their regulations do not allow providing hospitals to be reimbursed to the extent necessary to provide an incentive to share. Army, for example, does not allow any direct local reimbursement. Navy allows a partial reimbursement of outpatient charges, and Air Force indirectly reimburses through the budget process. Also many DOD hospital officials told us they lacked an incentive to share because their facilities would not be reimbursed.

Failure to agree on reimbursement rates

In VA's dealings with other Federal agencies, full cost reimbursements are generally required before VA provides services to other Federal agencies' beneficiaries. On the other hand, DOD is willing to provide to or procure services from other Federal agencies (e.g., VA) only on the basis of interagency rates. Full cost and interagency rates are very rarely the same. As a consequence, sharing between these Federal agencies is limited because of their failure to arrive at mutually agreeable reimbursement rates.

This point is clearly demonstrated in several case studies (see app. IV, case studies 2, 7, 8, 9, 11, and 14) and through our discussions with DOD officials. For example, Madigan Army Medical Center was prevented from providing renal dialysis to Seattle VA patients because estimated costs were higher than allowable DOD outpatient interagency rates. (See app. IV, case study 2.) Officials of the Army Health Services Command and the Office of the Army Surgeon General told us that interagency rates apply for both purchasing and providing direct care and supplemental care to other Federal agencies.

Navy officials also indicated that direct care services exchanged with other Federal agencies would have to be made on the basis of interagency rates. Port Hueneme Naval Hospital officials said they did not know whether Navy could reimburse VA as it did community physicians and hospitals from its supplemental care funds for services beyond Port Hueneme's capabilities. Subsequently, they contacted a Navy Bureau of Medicine and Surgery official, who said he knew of no procedures allowing the Navy to pay from supplemental funds.

Nevertheless, in a followup with the Bureau, the Deputy Comptroller told us that the Navy may consider actual (full) cost-sharing agreements with VA, but for supplemental care only. He said that the Economy Act is Navy's authority for interagency sharing, but Navy would probably be willing to enter into formal VA sharing agreements under 38 U.S.C. 5053 at full cost. No specific authority permits Navy to pay full costs, but there is no direct prohibition either. Therefore, Navy would consider a sharing agreement since it would be unfair to expect another agency (e.g., VA) to perform an expensive outpatient procedure for the Navy at a rate substantially lower than VA's full cost.

However, a formal sharing agreement would be considered only for supplemental care. In this case, the patient would not be disengaged from the Navy hospital and would continue to remain the Navy's responsibility. The hospital obtaining supplemental care would be responsible for reimbursement at rates prescribed by the providing facility. For all other types of direct patient referrals--inpatient or outpatient--the Bureau would reimburse the other Federal agencies at interagency rates.

Air Force headquarters officials stated that VA may be paid interagency rates for both direct and supplemental patient care, but actual practice differs in approaches to supplemental care. For example, patients from both the Davis-Monthan and

Kirtland Air Force Hospitals have received supplemental care from VA hospitals, but the different rates paid by these hospitals have caused problems. When Davis-Monthan was instructed to use interagency rates, a formal sharing agreement with VA was never finalized, while Kirtland has continuously paid full costs under a formal sharing agreememt for supplemental services rendered by VA. (See app. IV, case studies 8 and 12.)

CHAPTER 3

CONCLUSIONS, RECOMMENDATIONS, AND AGENCY COMMENTS

CONCLUSIONS

The Federal Government has a unique opportunity to take the lead in medical resource sharing. To take full advantage of this opportunity will, however, require action by the Congress and a concerted effort by the involved agencies to eliminate obstacles to sharing and establish a Federal health care delivery system which would more efficiently use the systems administered by DOD, VA, and PHS.

Legislative and administrative obstacles to sharing could be eliminated without adversely affecting the level or quality of care given to each agency's primary beneficiaries. Eliminating the obstacles and implementing a structured Federal interagency sharing program would benefit both the Federal Government and the beneficiaries.

Increased sharing would benefit the Federal Government by providing opportunities for:

--Eliminating or consolidating underused or duplicative facilities, equipment, and staff.

--Reducing the reliance on health delivery programs such as CHAMPUS and CHAMPVA, which provide the care not available from DOD, VA, or PHS.

--Increasing staff proficiency and improving patient care by consolidating workloads and resources.

Beneficiaries might be able to be treated in Federal facilities closer to their residences. Also they might save money because CHAMPUS and CHAMPVA require individuals to pay specified portions of the cost of care.

The Economy Act and VA and PHS sharing laws are subject to interpretation and/or permit only certain types of resources to be shared. Consequently, it is difficult for agencies to use such legislation to increase interagency sharing because, frequently, Federal officials do not know what the specific groundrules are for such sharing. Therefore, little substantive and uniform guidance has been provided to local Federal hospital officials on interagency sharing problems and questions.

Several DOD, VA, and PHS officials have, over the years, pursued sharing arrangements. More recently, increased emphasis has been placed on the issue of sharing, particularly through the establishment of the interagency Federal Health Resources Sharing Committee. However, little additional sharing has yet actually taken place. If the amount of individual effort toward sharing in several cases we identified has failed to produce active sharing agreements, little chance exists for interagency sharing where Federal medical officials are not interested in sharing or do not know how to deal with other agencies' officials. Also, unless obstacles to sharing are eliminated, further efforts initiated by individual Federal officials or the Committee will continue to be impeded.

Agency regulations on interagency sharing are often vague and difficult to interpret. Such regulations make it very difficult for local Federal hospital and clinics to share because most regulations imply or agency policy dictates that there are not excess capabilities in any treatment areas and that services should be provided only in emergencies or when previous allocations of resources have been made. Also one agency's regulations are often difficult to mesh with another agency's regulations, and consequently few sharing agreements can be executed.

The lack of an effective and uniform reimbursement mechanism is the major obstacle at the individual Federal hospital and clinic level to increased interagency sharing. Any corrective action must incorporate an incentive to share. In this regard we believe a uniform provision to reallocate any reimbursement received back to the providing hospital is essential. Furthermore, we believe that any reimbursement mechanism should be flexible enough to encourage and permit negotiations between local Federal hospital officials to determine acceptable rates of reimbursement for services shared. Negotiated reimbursements could be based on all costs funded from current appropriations, incremental costs (costs in excess of fixed costs for an additional item of service), or some other cost which is mutually agreed upon. In any case, the reimbursements would be agreeable to both parties, excess Federal capability would be used, and sharing would take place.

Legislation is needed to require interagency sharing when appropriate and to encourage the establishment of Government-wide implementing procedures. Such legislation should encourage individual initiative without affecting any Federal agency's organizational or command structures. It should

also give increased management options to local Federal medical officials to make the best use of our Nation's medical resources.

In view of the increasing concern in the Nation regarding the spiralling costs of health care, enacting legislation which establishes a firm Federal policy to promote Federal interagency sharing and removes restrictions on the types of services which can be shared would be both beneficial and timely. Enacting such legislation would also complement the national health priorities established by the National Health Planning and Resources Development Act of 1974 and provide the impetus and direction needed by Federal agencies to make interagency sharing more a rule than an exception.

RECOMMENDATIONS TO DOD, HEW, AND VA

We recommend that the Secretaries of Defense and Health, Education, and Welfare and the Administrator of Veterans Affairs:

--Jointly direct the Federal Health Resources Sharing Committee to expeditiously seek solutions to the administrative obstacles within each agency which impede sharing.

--Individually report annually to the appropriations committees of the Congress on the progress being made in implementing an effective sharing program.

RECOMMENDATIONS TO OMB

We recommend that the Director, OMB, establish a management group within the existing OMB organizational structure to work with DOD, HEW, and VA to coordinate the development of an effective interagency sharing program. Such a group should also work with Federal Health Resources Sharing Committee, and with OMB officials responsible for reviewing budget requests for Federal health care delivery activities to foster interagency sharing.

RECOMMENDATIONS TO THE CONGRESS

We recommend that the Congress enact legislation which would:

--Establish a policy that directs interagency sharing of Federal medical resources when appropriate.

--Authorize each Federal health provider to accept all categories of direct care beneficiaries on a referral basis when it would be advantageous to the Federal Government and care of primary beneficiaries would not be adversely affected.

--Eliminate all restrictions on the types of medical services which can be shared between Federal facilities.

--Authorize field hospital managers to approve agreements between Federal facilities, subject to headquarters veto only if judged not in the best interests of the Government.

--Permit agencies to expand services to treat beneficiaries of another Federal agency when such services would benefit the patient and the Government.

--Establish a policy requiring Federal facilities to use, if practical, nearby Federal direct health care resources before referring patients for care under programs such as CHAMPUS and CHAMPVA or to distant facilities within their own health care systems.

--Authorize the establishment of a reimbursement mechanism based on negotiated costs with a provision to reimburse the providing hospital with any revenues received to offset any expenses incurred. (This mechanism would allow Federal hospital officials to agree upon equitable and consistent fees on a medical service-by-service, hospital-by-hospital basis.)

--Assign to OMB the responsibility to (1) coordinate the implementation of an effective interagency Federal medical resources sharing program and (2) report annually to the Congress concerning the progress being made toward increased sharing of these resources.

Included in this report as appendix V is proposed legislation which we believe would provide the legislative mandate necessary to implement an effective Federal medical resources sharing program.

EVALUATION OF AGENCY COMMENTS

The Departments of Defense and Health, Education, and Welfare generally agreed with the conclusions and recommendations in a draft of our report, except those relating to reimbursements for services shared between Federal hospitals.

(See apps. VI and VII.) VA (see app. VIII) did not agree with the management or funding concepts advocated in our draft report. Further, VA believed that our recommendations were not in accordance with "accepted and recognized Federal agency management principles and could be inadequate as a matter of law."

OMB (see app. IX) said that it was concerned about many of the problems discussed in our draft report. However, it was unwilling to take a position on the changes recommended for congressional action without additional detailed analyses and the determination of the potential impact of the recommended legislative changes. OMB disagreed with our recommendation that it establish a group to work with Federal agencies to coordinate the development of an effective interagency sharing program.

Reimbursements for shared services

Our draft report proposed that incremental costs become the legal basis for reimbursement for medical services exchanged among Federal agencies. This proposal was based on the fact that full cost reimbursements are not necessary. Full costs do not represent the "out-of-pocket costs" of providing services since costs such as salaries and utilities would be incurred whether or not services were provided to other agencies' beneficiaries. Also, the use of full costs would not provide adequate incentives for interagency sharing if lower rates were available in non-Federal hospitals. Therefore, incremental costs--those costs incurred for the provision of an additional item of service--appeared to be the logical choice as a basis of reimbursement for interagency sharing.

DOD, HEW, and VA all disagreed with the proposed recommendation. DOD and VA stated that reimbursements between agencies for shared services should be based on actual costs. DOD said that, when its uniform accounting system for military hospitals is fully implemented, it will be capable of identifying costs for specific medical services to the degree that separate fees can be set for these services. DOD also said that reimbursement rates should be established centrally rather than by hospital. VA said that interagency reimbursements should be based on actual costs which represent an average uniform rate. It said that its billings should not be based on two rates--one for Federal beneficiaries and another for non-Federal institutions. HEW believed reimbursement between agencies should be made on a cost of service basis but recognized that it might be desirable to share resources by means of even exchange. Regardless of the cost basis adopted, HEW suggested that the specific reimbursement

mechanism should be left to the agencies to develop within broad general agreements negotiated by, for example, the Federal Health Resources Sharing Committee.

In view of the agencies' comments on this proposed recommendation and because the agencies' accounting systems do not now identify elements of cost for individual medical services, we are now recommending that reimbursements for shared services be negotiated and mutually agreed to by local Federal hospital administrators. As the agencies' willingness to share increases and their cost accounting systems become more sophisticated, it seems reasonable to us to expect that incremental costs could eventually become the standard basis of reimbursements for medical services shared between Federal agencies.

DOD concurred in our recommendation that reimbursements received by individual hospitals for shared services be returned to providing hospitals as an incentive to promote interagency sharing of Federal medical resources. HEW did not agree, stating that hospitals providing services to other agencies' beneficiaries should be funded on the basis of total workload regardless of origin, with reimbursements paid centrally and credited to the agencies' total budgets. According to HEW, to do otherwise would tend to unbalance the distribution of an agency's resources and create an undesirable competition for patients and the financial resources they represent.

VA emphasized that it believes it has an effective and consistent mechanism under which it seeks reimbursement for services rendered to other Federal facilities in two ways--either by an interagency agreement (under 31 U.S.C. 686) or a sharing agreement (under 38 U.S.C. 5053). VA stated that in both instances actual costs are realized in accordance with present legislation. Our review showed that the ways in which cost reimbursements under these two statutes are recovered in actual practice differ substantially. In practice, the different reimbursement mechanisms favor the sharing of VA's resources with non-Federal health providers rather than Federal agencies.

As discussed earlier, reimbursement rates under interagency agreements are derived from establishing average daily inpatient and outpatient rates based on total annual operating costs and total annual inpatient and outpatient workloads. Therefore, the rates do not reflect the full actual cost of each medical service provided. In effect, VA receives as reimbursement only an "average actual cost" which, in the case of highly specialized procedures, may be substantially

less than a VA hospital's full cost of providing the services. In addition, reimbursements generated as a result of interagency agreements are not reallocated back to the individual VA hospital which provided services to other agencies' beneficiaries. Therefore, from the perspective of the individual VA hospital, the only readily identifiable benefit to sharing under interagency agreements is that the workload generated through sharing is counted as part of its overall workload upon which its annual budget allowances are calculated.

However, if the target budget allowance for a VA facility is, for any reason, reduced, interagency sharing--ongoing or planned--must be curtailed since the facility's first obligation is to serve eligible veterans. Under these circumstances if any sharing occurs, the facility must absorb the costs of such efforts as part of its reduced budget allocation.

On the other hand, the reimbursement mechanism used by VA to provide services under sharing agreements is substantially different from that under interagency agreements. Under sharing agreements, reimbursements are received by the VA Central Office for the full cost of each specific service provided. The revenues collected are subsequently reallocated, on a quarterly basis, to the VA hospital which provided the service. In addition, the workload generated because of sharing is also included in the individual VA hospital's workload statistics used as the basis to request appropriations for operating funds from the Congress. In effect, a VA hospital which provides services under sharing agreements could receive a double payment for the services it provides to others.

The differences in VA's reimbursement mechanism under the two sharing authorities have, in our opinion, historically contributed to the lack of significant sharing between VA and other Federal agencies. Nearly all of the services VA provides for other Federal hospitals have been provided under interagency agreements because either (1) VA Central Office officials believe these are the appropriate agreements for its hospitals to use in dealing with other agencies or (2) the other agencies are willing to reimburse VA only based on rates established under interagency agreements--that is, those based on the average actual costs of services VA provides to their beneficiaries. In contrast a substantial volume of services (about $16 million in fiscal year 1977) is shared between VA and non-Federal health providers under its sharing agreement authority but very little (about $26,000 in fiscal year 1977) is shared between VA and other Federal agencies, although this authority specifically

authorizes VA to share specialized services with other Federal hospitals. Because the reimbursement mechanism under interagency agreements provides local VA hospitals little incentive to share while the mechanism under sharing agreements provides them much greater incentives, it is easy to understand why VA's sharing with other Federal agencies has been limited.

Other Comments

DOD and HEW

Both DOD and HEW expressed their support for the concept of increased interagency sharing of Federal medical resources and cited several actions that have already been taken toward this objective. The departments agreed in principle with our recommendations that:

--Federal agencies be permitted to expand services to treat beneficiaries of another Federal agency when such services would benefit the patient and Government,

--local hospital managers be permitted to negotiate sharing agreements, and

--a policy be established requiring Federal facilities to use nearby Federal resources before selecting other more costly or distant sources of treatment.

DOD agreed with the last of the above recommendations but stated that it did not want its patients to travel beyond 40 miles from their place of residence to obtain such care. Neither DOD nor HEW wanted to be required to first use other Federal facilities. DOD expressed the view that the policy we recommend should be flexible enough to allow for exceptions on a case-by-case basis when such exceptions would benefit other activities, such as military medical teaching programs. HEW expressed concern that, if services could be obtained at a lower cost from private sources, there should be no requirement to use a more costly Federal source of care.

We agree that a policy requiring interagency sharing should not be so rigid as to allow for no exceptions. However, we do not agree that the imposition by DOD of a strict rule regarding the distance patients live from a Federal medical treatment facility should be included as a blanket exception to the policy we are recommending. In this regard, DOD now routinely transports many patients great distances on its domestic aeromedical evacuation system to receive

care. We believe that, unless a transfer to a distant Federal medical facility can be fully justified based on the specific medical care needs of the patient, lower costs in the private sector, or in rare instances, the needs of a medical teaching program, sharing with nearby Federal facilities should be required.

VA

VA recognized the need for development of a coordinated approach to health care planning among Federal agencies and pointed out the recent contributions that its Department of Medicine and Surgery has made toward establishing the Federal Health Resources Sharing Committee. It stated its belief that administrative remedies would be more appropriate than legislative remedies to overcome the obstacles to sharing we identified.

VA also said it would be remiss if it did not address certain policy issues that would affect the implementation of our recommendations. In this regard, VA stated that the American people, acting through the President and the Congress, have expressed a special concern for its citizens who have devoted parts of their lives to the Nation's defense. Medical care to these veterans has been the mission of VA since 1930, and the creation in 1946 of VA's Department of Medicine and Surgery made VA solely responsible for the treatment of veterans.

VA believed that our recommedations seem to favor an amalgamation of resources for the benefit of all beneficiaries in the Federal sector. It stated that our recommendations must be considered in accordance with VA's primary mission of caring for veterans. Further, according to VA, since (1) there is no agreement on VA's role in any forthcoming national health insurance program and (2) various options are still being considered by the President concerning the provision of the Nation's health care needs, it would be unwise to enact legislation implementing our recommendations.

We do not agree with VA's statementsrregarding the policy implications of our recommendations. Throughout our review we have recognized the concerns of the involved agencies regarding their primary mission and have developed our recommendations with these concerns in mind. The implementation of our recommendations would not, as VA has indicated, necessarily result in a "amalgamation" of Federal health resources. Rather their implementation would enhance the abilities of each agency's hospital directors to seek and

obtain alternative sources of care for their beneficiaries, while taking advantage of opportunities to control the Government's increasing health care costs.

Regarding VA's concerns about the future direction of Federal health care, we believe that the Government, through the initiation of a congressionally directed and effectively implemented interagency sharing program, has a unique opportunity to take the lead in health care planning and coordination activities. Such activities will undoubtedly become important factors in future programs developed to control the Nation's health care costs.

OMB

As previously discussed, OMB did not agree that it should establish a group to work with the involved agencies to coordinate the development of an effective sharing program. OMB said it would rely on its budget examiners and other staff already working with the agencies affected by our recommendations in considering further actions to address sharing problems.

We believe that the issue of sharing medical resources among Federal agencies has progressed to the point where OMB should assume a stronger role than it has in the past. The divergent views expressed by DOD, VA, and HEW concerning our report indicate a lack of an overall executive branch policy on this issue. We believe that OMB's traditional reliance on its budget examiners to recommend the proper course of action for an interagency sharing program will be inadequate because its organization of budget examiners is structured along individual agency lines. HEW, in its comments, suggested that centralization of sharing coordination within OMB should be a managerial rather than a budget process so that it might be prospective, affirmative, and guiding in its approach. We agree and believe that the establishment of a managerial group within the existing OMB organizational structure to work with the recently established Federal Health Resources Sharing Committee, the involved agencies, and OMB budget examiners is essential to the development of an effective Federal sharing program.

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Over the years, Federal agencies have become increasingly concerned with their abilities to provide quality health care to their primary beneficiaries. However, little attention has been given to taking advantage of the opportunities to improve patient care and reduce Federal health

care costs through interagency sharing of medical resources. In fact, because of the emphasis on individual agencies' capbilities, several obstacles have evolved which now make sharing--even when it is tried--much more difficult. We endorse the establishment of the Federal Health Resources Sharing Committee as a vehicle to discuss agencies' mutual interests. However, we believe the enactment of legislation to provide the impetus for an effective Federal medical resources sharing program and a concerted effort by the involved agencies to make sharing a routine occurence are essential if the Government's direct health care providers are to realize their full potential.

CHAPTER 4

SCOPE OF REVIEW

We made our review at the headquarters offices and selected health care facilities of DOD, VA, and HEW, the three major Federal direct health care providers. Our general objective was to evaluate and substantiate the feasibility and desirability of increased interagency sharing. We concentrated on identifying obstacles to sharing. In identifying legislative and administrative obstacles, we concurrently identified potential opportunities for interagency sharing.

In identifying obstacles we analyzed existing legislation and regulations pertaining to interagency sharing. We obtained interpretations of the legislation and regulations from officials of DOD's Office of Assistant Secretary of Defense (Health Affairs); Offices of the Surgeons General of the Army, Navy, and Air Force; the DOD Health Council; various VA Central Office officials, including the Administrator of Veterans Affairs; and PHS' Bureau of Medical Services. Our work with these officials was conducted at their headquarters offices in the Washington, D.C., area. We also visited Army's Health Services Command in San Antonio.

To identify obstacles at the field level, we discussed with Federal hospital managers their interpretations of legislation and regulations affecting their dealings with other agencies. We developed information at individual Federal hospitals and clinics for subsequent use as case studies to demonstrate opportunities for sharing and obstacles to sharing. We met with VA medical district directors and their staffs, DOD regionalization coordinators, and civilian health planning officials to solicit their views on sharing Federal medical resources. Also we used data developed for us by CHAMPUS headquarters in Denver to determine whether Federal hospitals could have absorbed some of the CHAMPUS workload being provided by civilian facilities in selected geographic areas.

HOSPITALS AND CLINICS REVIEWED

The following Federal hospitals and clinics were reviewed:

Seattle-Tacoma, Washington, area

Madigan Army Medical Center
Naval Regional Medical Center, Bremerton
Naval Hospital, Whidbey Island
Veterans Administration Hospital, Seattle
Veterans Administration Hospital, American Lake
U.S. Public Health Service Hospital, Seattle

San Francisco, California, area

Letterman Army Medical Center
Naval Regional Medical Center, Oakland
David Grant Medical Center (Travis Air Force Base)
Veterans Administration Hospital, San Francisco
Veterans Administration Hospital, Martinez
U.S. Public Health Service Hospital, San Francisco

Los Angeles, California, area

Naval Regional Medical Center, Long Beach
Naval Hospital, Port Hueneme
Air Force Regional Hospital, March Air Force Base
Veterans Administration Hospital, Long Beach
Veterans Administration Hospital, Loma Linda

San Diego, California, area

Naval Regional Medical Center, San Diego
Veterans Administration Hospital, San Diego

Tucson, Arizona, area

Air Force Hospital, Davis-Monthan Air Force Base
Veterans Administration Hospital, Tucson
Indian Health Service, Tucson

Albuquerque, New Mexico, area

Air Force Hospital, Kirtland Air Force Base
Veterans Administration Hospital, Albuquerque

Colorado-Wyoming area

Fitzsimons Army Medical Center, Denver, Colorado
Air Force Hospitals F.E. Warren Air Force Base, Cheyenne, Wyoming
Air Force Clinic, Lowry Air Force Base, Denver, Colorado
Veterans Administration Hospital, Denver, Colorado
Veterans Administration Hospital, Cheyenne, Wyoming

Temple, Texas, area

Darnall Army Hospital (Ft. Hood)
Veterans Administration Hospital, Temple

Tampa, Florida, area

Air Force Regional Hospital, MacDill Air Force Base
Veterans Administration Hospital, Tampa
U.S. Public Health Service Clinic, Tampa

Miami-Key West, Florida, area

Naval Hospital, Key West
Air Force Hospital, Homestead Air Force Base
Veterans Administration Hospital, Miami
U.S. Public Health Service Clinic, Miami

Lexington, Kentucky, area

Veterans Administration Hospital, Lexington
Federal Correctional Institution, Lexington
National Institute of Drug Abuse, Addiction Research Center, Lexington

New England area

Cutler Army Hospital (Ft. Devens), Massachusetts
Naval Regional Medical Center, Newport, Rhode Island
Air Force Clinic, Hanscom Air Force Base, Massachusetts
Veterans Administration Hospital, Boston, Massachusetts
Veterans Administration Hospital, West Roxbury, Massachusetts
Veterans Administration Hospital, Brockton, Massachusetts
Veterans Administration Hospital, Bedford, Massachusetts
Veterans Administration Hospital, Providence, Rhode Island
U.S. Public Health Service Hospital, Boston, Massachusetts

MAJORITY MEMBERS
GEORGE H. MAHON, TEX.,
CHAIRMAN

MINORITY MEMBERS

Congress of the United States
House of Representatives
Committee on Appropriations
Washington, D.C. 20515

January 10, 1977

Honorable Elmer B. Staats,
Comptroller General of the United States
General Accounting Office
441 G Street, N.W.
Washington, D.C. 20548

Dear Mr. Staats:

As you know, the Committee recently requested that your Office conduct two studies to determine the potential for Federal agencies such as the Departments of Defense and Health, Education and Welfare, and the Veterans Administration to share expensive and highly specialized cardiac catheterization and computed tomography capability. It appears from discussions with your representatives that Federal sharing of these services could yield savings to the Government.

We understand that your Office's Human Resources Division is considering initiating a broader study to determine whether additional opportunities exist for agencies to share perhaps less specialized but possibly equally expensive Federal delivery capability and to identify the legislative, administrative and other obstacles that might currently exist to preclude the optimum use of Federal capability through sharing.

The Committee requests that emphasis be placed on such a study in view of the rapidly increasing costs involved in the delivery of health care. We are particularly interested that any opportunities available to share existing Federal health capability without adversely impacting on the quality of care being provided be explored carefully.

The Committee understands that such a review will be a complex and time-consuming undertaking and therefore is not requesting a report until January 1978. However, we would appreciate remaining apprised of the progress of the review so that information being developed can be discussed with the officials of the departments and agencies requesting

APPENDIX I

appropriations for the provision of health services and for the construction of additional health facilities.

The Committee looks forward to receiving a report on the results of your review and particularly your recommendations for overcoming the obstacles to the full sharing of Federal health resources. The staff of the Committee remains available to discuss the details of this request. Thank you for your assistance in providing the Committee with assistance in this increasingly costly area of Federal activity.

Sincerely,

George Baker

Chairman

PRIOR STUDIES INDICATE CONTINUOUS CONCERN OVER MANAGEMENT AND PROPER USE OF FEDERAL MEDICAL RESOURCES

Over the past 30 years, several reports and studies have discussed the proper type of management needed by DOD, VA, and PHS to more effectively operate their medical facilities. Several of these studies were conducted because of legislative requirements or because of congressional direction. These reports have addressed, on various occasions, management of one agency's own resources in a specified geographical area (regionalization), use of one agency's resources by another agency (sharing), and management of the separate health care delivery systems under one administration (unification). In addition, for the past several years we have issued several reports which demonstrate that Federal hospitals can better use medical resources.

HOOVER COMMISSION REPORTS

In 1947 and 1953 the Congress established Commissions on Organization of the Executive Branch of the Government to determine what changes were necessary to promote economy, efficiency, and improved service in, among other things, the delivery of health-care by Federal agencies. These Commissions were commonly known, respectively, as the First and Second Hoover Commissions.

First Hoover Commission Report

The first Commission's March 1949 report to the Congress criticized:

--Medical construction programs going forward although Federal hospitals had unused capacity.

--The lack of planning by Federal agencies with little knowledge of, and no regard for, the needs of the Nation as a whole.

--The lack of a clear definition by the Congress of the rights and priorities to medical care of all the classes of beneficiaries. (The Commission believed that hospital care for Federal beneficiaries should be planned in relation to the hospital resources of the country as a whole, not merely through construction of Federal hospitals.)

Second Hoover Commission Report

The second Commission's February 1955 report to the Congress indicated that little fundamental improvement in Federal medical services had been made since the issuance of the first Commission report in March 1949.

The second Commission report pointed out similar examples of waste and lack of coordination identified by the first Commission. The Commission proposed specific remedial actions, including:

--Creating a Federal Advisory Council of Health where medical policies and activities could be reviewed to further coordination, eliminate duplication, and develop overall policies.

--Developing regional coordinated administration of military hospital services.

--More cross-servicing between the military hospitals and between VA and PHS hospitals.

The Commission recommended creating a Federal Advisory Council of Health because the responsibility of recommending overall Federal policies was not fixed in any executive branch unit. Consequently, because of this lack of overall policy, excessive duplication of programs, facilities, and personnel existed. Such excesses, in its opinion, not only impaired the economic and efficient operation of Federal health activities, but placed unreasonably heavy claims upon the Nation's total health economy.

The Commission thought that its recommendations could be put into lasting effect only if they became the explicit responsibility of a permanent council. The Commission concluded that the best place for such an organization was within the Executive Office of the President.

DOD STUDIES

The organizational structure of the military's health care delivery systems has been an issue since DOD was established in 1947.

Each study tried to determine how to obtain increased efficiency and economy from three distinct health care systems (Army, Navy, and Air Force) with each health care system controlled by a different surgeon general. Options presented in these studies ranged from no change to unification of the systems into one entity. Regionalization--

collectively organizing and managing a system of peacetime health care delivery in specified geographic areas in order to increase productivity and achieve economy without unnecessary duplication of resources--has emerged as a compromise between the two extremes.

Major studies and a brief discussion of the views expressed in each follow.

DOD Committee on Medical and Hospital Services of the Armed Forces (1949)

The Committee examined three alternative organizational structures: a unified medical service supporting all three military departments; a single manager plan, under which one service would be responsible for military medicine in support of all military departments; and separate but coordinated medical services for each military department.

The Committee rejected a single medical service in any form, noting

> "separation of the medical services from the departments they serve and sustain * * * would greatly reduce the efficiency and effectiveness of the medical services in rendering medical support to the various departments and agencies of the National Military Establishment."

They recommended coordination and policy guidance at the Secretary of Defense level.

Armed Forces Medical Advisory Committee (1949)

This Committee was a military-civilian group formed to to advise the Secretary of Defense on health and medical matters. In the first half of 1949, the Committee considered a Joint Chiefs of Staff recommendation that "the Secretary of Defense immediately institute studies and measures intended to produce, for the support of the three fighting services, a completely unified and amalgamated [single] medical service."

Military medical department summaries of that study indicate that the Committee had concluded that "the objectives of unification are highly desirable" but stated further that "so much of the medical department as is essential for medical support of each of the Armed Forces [should] remain as integral parts of these forces."

Coller Report (1958)

This report was prepared in response to President Dwight D. Eisenhower's request that Dr. Frederick Coller, a non-DOD physician, determine if it would be advantageous to designate one service as the single manager for military health services. Dr. Coller's report supported the continuation of three separate but coordinated medical departments.

Comprehensive Medical Services Program Review Report on Unification of Military Medical Departments (1966)

None of the Program Review Group believed that continuing the status quo was a satisfactory answer to the needed management of DOD medical resources. On the other hand, most members initially preferred to avoid the other extreme of complete unification.

However, the growing realization and appreciation of the complex and interlocking nature of each military department's medical service led the participants to conclude that unification to the greatest degree possible was the only viable and worthy alternative. As a result the report recommended establishing a Defense Medical Service and concurrently disestablishing the Offices of the Surgeons General of the three military medical departments.

Clifford/Nitze Report (1968)

This report was prepared because Secretary of Defense Clark Clifford had been asked by a Special Assistant to the President for his views on unification of the military health services. Deputy Secretary of Defense Paul Nitze stated that unification was not desirable or feasible.

Reasons cited were that many functions already were consolidated and a substantial and critical portion of each medical service was closely integrated with the force it supported. Consequently, as long as the services maintained their separate identities, unification was not realistic.

DOD-HEW Study ("Reducing the Needs for Military Medical Personnel in the Armed Forces") (1972)

This study recommended that:

--A peacetime health services system be regionalized on a triservice basis.

--Military health care facilities be partially staffed with civilian health professionals on a contractual basis.

"Military Health Care Study" (1975)

This study, undertaken at the direction of the President, was made to (1) assess the ability of the current military health care system to meet the future needs of the Armed Forces and (2) recommend ways to ensure quality medical care for all DOD beneficiaries which were consistent with the national health care initiatives and DOD's missions and objectives.

The study was conducted by representatives of DOD, HEW, and OMB. Of particular importance to DOD's management of resources were these recommendations:

--A central DOD coordinating entity for planning and allocating resources should be established to oversee health care delivery in the continental United States.

--Oversight of health care delivery should be assigned to regional authorities responsible for all health care delivery in their geographical areas.

As a result of the first recommendation, a DOD Health Council was established in December 1976 to coordinate DOD health care activities.

Report on the Feasibility of Sharing Medical Facilities (1976)

In this report the Assistant Secretary of Defense (Health Affairs) reported to the Chairman, Senate Appropriations Committee, as requested during the fiscal year 1977 DOD appropriations hearings, on the feasibility of sharing medical facilities. The Assistant Secretary stated that DOD solidly agreed with the idea of sharing and pointed out the extent to which it already existed. The report concluded that a significant amount of cooperation, coordination, and sharing currently existed between DOD, VA, and PHS. However, the Assistant Secretary cautioned that the achievable level of sharing was limited by the following factors:

--The health programs of each group are somewhat unique based on the beneficiary population served. This is particularly evident in program differences emphasizing short-term care versus long-term chronic care.

--DOD must provide adequate staff and facilities to support wartime mobilization. This core of resources is most efficiently used during peacetime to care for additional beneficiaries on a space-available basis.

--An appropriate balance between the Federal agencies must be achieved which will not result in care not being available when surges in demand occur.

--Medical practice currently emphasizes ambulatory care, a service in short supply for all Federal agencies. Opportunities for sharing are limited by the few locations where more than one Federal facility is present and at least one has capacity it can share.

Comparative Health Facility Acquisition Methodology Study (1977)

In February 1976 the Subcommittee on Military Installations and Facilities, House Committee on Appropriations, became concerned with the increased cost of acquiring military health facilities. Testimony before the Subcommittee revealed that estimates for construction of newly designed facilities sometimes increased by over 100 percent from original preliminary estimates.

DOD was directed to undertake a study for the purpose of making recommendations that, if implemented, would hold down the costs of providing military health facilities, while providing an acceptable health care delivery capability.

The following recommendations from the study were among those considered to have the highest priority for implementation because of their potential impact:

--Accelerate the implementation of a regional military health care system. All alternative resources which can provide health care more economically should be considered in assessing the need for and the planning of any new facility. This assessment should include shared services, cooperative efforts, and other program methods between military health care facilities and between the military and VA and/or civilian facilities.

--DOD, VA, and HEW should establish a Coordinating Council for the planning/programing of health care facilities. The Council's mission would be to stimulate and implement the sharing of ideas and information; discuss problems common to all agencies; and

coordinate efforts to accelerate progress and avoid significant duplication of effort.

VA STUDIES

Since the mid-1960s, VA has been authorized to share its specialized services with non-VA medical facilities. One major report addresses issues involved in the VA regionalization and sharing programs.

"Health Care for American Veterans" (1977)

On June 3, 1977, the National Academy of Sciences' Committee on Health Care Resources in VA released this report. Overall the committee was particularly interested in learning why the scope of shared services, both between VA and non-VA hospitals and between VA hospitals, remained so small 10 years after the Congress had authorized sharing. It also wanted to explore the extent to which the parallel policies of sharing between VA and outside facilities and regionalization within VA were compatible.

The committee found that 92 percent of all the services bought and sold by VA under sharing contracts in fiscal year 1975 had been exchanged between VA and non-VA hospitals affiliated with the same medical school. The committee concluded that this situation had probably occurred because the physician specialist in charge of the shared services was on the staff of both hospitals and therefore could coordinate patient care, teaching, and research in both hospitals. In cases of specialized medical services, the committee found, in almost all cases, evidence of operation below minimal standards and under the present circumstances, no workable local mechanisms or incentives to foster sharing. Because sharing agreements are initiated and continued by individual VA hospital officials, the incentives to fostering sharing are important. Except for the situations involving affiliated hospitals, the committee found no incentives to share with non-VA hospitals.

The committee also found the interpretation of sections 5051 to 5053 of title 38 by the VA General Counsel to be too restrictive. These sections allow VA to share specialized medical resources with non-VA health care facilities. Moreover, the committee believed changes in incentives and VA budgetary procedures were necessary to realize the potential benefits of sharing between VA and non-VA facilities.

The committee could not arrive at a definite assessment of the VA regionalization program because VA was pilot testing a new system in 6 of the 28 medical districts. VA hoped this new system would reduce duplication of costly medical programs and promote sharing between VA hospitals in the same medical district. However, the committee cautioned that the emphasis of allocating medical resources among VA facilities had the potential for reinforcing the separation of VA facilities from local non-VA facilities. Therefore,

> "by not considering the availability of specialized and other medical services in the non-VA sector before allocating these resources to the network of VA hospitals, the VA * * * limited the alternatives from which to choose the best way to make specialized and other medical services available and easily accessible to its patients."

PHS

Neither HEW nor any outside parties have completed formal studies or reports on sharing PHS medical resources with other Federal agencies. However, during the past 15 years a series of congressional hearings has been conducted concerning the potential role of PHS hospitals. For example, the Webster Committee Report of June 19, 1965, recommended that:

--PHS continue to operate a system of general hospitals.

--PHS general hospitals be modernized and be supported at levels consistent with the several important functions they should perform.

--Additional training programs be developed in sciences and services basic to medicine and existing programs be strengthened and extended. Responsibility for these programs should be shared with universities and with other community health agencies.

GAO'S PRIOR STUDIES OF FEDERAL HOSPITAL SYSTEMS' OPERATIONS

Reports on DOD

We have issued three reports on DOD's use of medical resources in treating beneficiaries.

Our April 21, 1975, report entitled "Questionable Use of the Domestic Aeromedical Evacuation System" (MWD-75-45)

to the Secretary of Defense discussed how the domestic segment of the worldwide patient airlift system operated and suggested improvements. On the basis of questionnaire responses and other information, we concluded that the need for the system as it currently operated was questionable. For example, responses showed that 80 percent of the referrals could have received care at or near their originating military facilities or at military facilities closer than those to which they had been transferred. Furthermore, about half the referrals could have been made by transportation means other than domestic aeromedical evacuation.

Our report to the Congress entitled "Policy Changes and More Realistic Planning Can Reduce Size of New San Diego Naval Hospital" (MWD-76-117, Apr. 7, 1976) examined the DOD criteria used to size new military hospitals. The criteria were deficient and their continued use would result in constructing hospitals with excess acute care beds.

Our report raised two policy questions for the consideration of the Congress.

1. Who were the new facilities being built for?

2. To what extent should DOD and other Federal hospitals be required to share excess acute care beds as an alternative to new construction?

The sharing question was raised because the San Diego VA Hospital and the Camp Pendleton Naval Hospital--both in the San Diego area--had 150 and 160 excess acute care beds, respectively. We suggested that sharing these facilities offered an attractive alternative to constructing new capacity at the San Diego Naval Hospital.

In July 1976 the Congress did give DOD the following policy guidance:

--A method of determining the number of acute care hospital bed requirements for active duty members and their dependents.

--Guidance on providing bed capacity for other eligible beneficiaries.

--Direction on the coordination needed between the Federal and civilian health care representatives.

Our report entitled "Congressional Policy Guidance Should Improve Military Hospital Planning" (HRD-77-5, Nov. 18, 1976) focused on the congressional guidance provided and DOD action needed to insure that future hospital planning was in accordance with this guidance.

Reports on VA

We have issued eight reports in the past few years which discussed primarily the use of VA's medical resources.

Our June 19, 1972, report to the Congress entitled "Low Use of Open-Heart-Surgery Centers at Veterans Administration Hospitals" (B-133044) discussed use of VA specialized medical services. As noted in several other reports discussed below, these services were underused in several locations. We recommended that the program be evaluated to redetermine the number and locations of open-heart-surgery centers needed.

Our April 11, 1973, report entitled "Better Use of Outpatient Services and Nursing-Care Bed Facilities Could Improve Health Care Delivery to Veterans" (B-167656) said VA could make better use of its outpatient services and the number of veterans referred to private dentists could be reduced if dental resources were better coordinated between neighboring VA stations.

In our November 13, 1973, report entitled "Need for Improvement in Certain Hospital Laboratory Service Activities" (B-133044) we discussed the need for improved program planning and management in certain areas. For example, although VA obtained most of its blood from volunteers, it could have obtained more by establishing a cooperative program with the military to obtain volunteer blood that exceeds the military's needs. Also the large number of electron microscopes acquired by VA had resulted in low overall use, and the future planned acquisition of additional units was questionable.

Our March 20, 1974, report to the Congress entitled "Complications Incurred Because of Delays in Transferring Patients to VA Spinal Cord Injury Treatment Centers" (B-133044) said spinal cord injury patients--particularly servicemen--were not being transferred to VA facilities as soon as medically feasible. Thus many incurred medical complications which slowed their rehabilitation, lengthened their hospitalization, and increased the cost of health care.

We recommended that:

--The Administrator of Veterans Affairs work with the military to develop a system to expedite the transfer of spinal cord injury patients to VA centers.

--The Secretary of Defense revise military procedures and regulations to permit transfer of spinal cord injury patients to VA centers as soon as medically feasible.

In our report entitled "Better Planning and Management Needed by the Veterans Administration to Improve Use of Specialized Medical Services" (B-133044, June 19, 1974) we reported to the Congress that VA hospitals had established and operated such specialized medical services as supervoltage therapy, kidney transplants, and hemodialysis, even though many were underused and duplicated existing facilities. VA, we said, could improve the management and operation of these programs. We recommended that VA establish, maintain, and periodically review criteria and guidelines; and provide necessary information to periodically evaluate the programs' effectiveness.

Reports on use of medical resources were issued to the Administrator of Veterans Affairs on September 17, 1975, and May 20, 1976. The first dealt with a need to share specialized medical services, specifically cardiac catheterization laboratories. The second was a followup of VA's laboratory operations to determine if an earlier report's recommendations ("Need for Improvements in Certain Hospital Laboratory Service Activities," B-133044, Nov. 13, 1973) had been effectively implemented.

The first report concluded that the establishment of a cardiac catheterization laboratory at the Sepulveda, California, VA Hospital had not been warranted because (1) patient demand for cardiac catheterization had not been determined and (2) based on available standards, the laboratory at the nearby Wadsworth, California, VA Hospital was underused even though patients had been transferred from the Sepulveda VA Hospital.

The second report concluded that VA's laboratory service fee-basis testing costs had been high and reducing these costs through regionalization efforts had been limited. This situation occurred because VA's Central Office had failed to actively control the progress of efforts to regionalize laboratory services or adequately evaluate and coordinate field activities.

Our February 28, 1977, report entitled "Many Cardiac Catheterization Laboratories Underused in Veterans Administration Hospitals: Better Planning and Control Needed" (HRD-76-168) examined the VA cardiac catheterization program and discussed the need for improved management of VA's policy for planning and controlling the expansion of its specialized medical services. Many VA cardiac catheterization laboratories were underused. Some laboratories unnecessarily provided this costly service, although it was available at nearby VA and community hospitals. In effect, VA did not follow its policy that specialized medical services, such as cardiac catheterization, be planned and provided on a regionalized basis to avoid duplicating or overlapping.

Report on PHS

A recent report (HRD-77-111) on the level and range of services provided by the PHS hospital system was issued on May 26, 1977, to the Chairman, Senate Committee on Appropriations. We addressed this issue to determine whether PHS was operating at the 1973 level as required by law. We believe that in considering funding for the PHS hospital system, the Congress should decide whether the Nation intends to realize the potential of this system as a resource for medical care at a reasonable, controllable cost. The Congress should consider the potential savings from providing health care to military dependents in federally controlled PHS facilities and the economies and efficiencies of PHS hospital participation in and cooperation with regional and local health planning and resource allocation organizations.

Multiagency reports

Our most recent audit efforts have concentrated on the opportunities available for the Federal health care delivery systems to effectively share certain costly specialized medical resources--cardiac catheterization laboratories and computed tomography scanners--and more effectively coordinate interagency planning.

Our report to the Congress entitled "Sharing Cardiac Catheterization Services: A Way to Improve Patient Care and Reduce Costs" (HRD-78-14, Nov. 17, 1977) said use levels varied widely at the nine DOD and VA catheterization laboratories in four geographic areas visited. Although VA had guidelines for planning catheterization laboratories, including recommended workload levels, DOD and PHS had no such guidelines.

We recommended that DOD, VA, and HEW develop uniform guidelines for planning and using Federal cardiac catheterization laboratories. We recommended that after the Federal guidelines are established, these agencies jointly analyze use levels of all their laboratories and adjust the way the service is provided so that it would be in accordance with the new guidelines. We suggested that at locations where the guidelines could not be met alone or through interagency sharing, consideration be given to closing Federal laboratories and obtaining the service from nearby civilian hospitals.

We also recommended that OMB oversee the efforts to develop these guidelines to be sure they were done in a timely manner and to insure that this diagnostic service was shared where patient care would be improved and cost savings result.

In another recent report to the Congress entitled "Computed Tomography Scanners: Opportunity for Coordinated Federal Planning Before Substantial Acquisitions (HRD-78-41, Jan. 30, 1978) we discussed the lack of a coordinated approach to planning and using scanners.

Neither DOD nor VA had formal guidelines and criteria to justify the need for and geographical placement of scanners. Also virtually no coordination took place between these two agencies in planning for scanners.

We recommended that the Secretaries of Defense and HEW and the Administrator of Veterans Affairs:

--Develop criteria for assessing and justifying the need for scanners and the most appropriate geographical placement.

--Establish a policy which would require, when possible, interagency sharing of scanners.

--Evaluate the feasibility and economies of using civilian capability before placing scanners in a Federal hospital.

In addition, OMB should oversee the efforts to develop a coordinated Federal approach to insure that it is developed promptly. We also recommended that the Congress explore the merits of limiting scanner acquisitions until such an approach is developed.

Our recent report concerning Federal health care in Hawaii ("Better Coordination Could Improve the Provisions of Federal Health Care In Hawaii," HRD-78-99, May 22, 1978) showed that although Federal health care there is generally readily available and accessible, facilities could be better used. Also there apparently is a unique opportunity available during the major renovation and construction project at the Tripler Army Medical Center to design a facility which will more closely meet the health care needs of all Federal beneficiaries in Hawaii.

Reports on use of medical resources nationwide

We issued a report on November 20, 1972, entitled "Study of Health Facilities Construction Costs" (B-164031(3)) pursuant to section 204 of the Comprehensive Health Manpower Training Act of 1971. This act directed us to study the feasibility of reducing the cost of constructing health facilities assisted under the Public Health Service Act. We identified and studied means by which health facility construction could be avoided by either reducing the demand for facilities or increasing their productivity. Means identified and studied included shared services and regional systems.

We found that sharing could free facilities for other purposes and could be effective in meeting demands for space without construction. Many hospitals, however, have been impeded from establishing sharing agreements because (1) physicians are reluctant to share hospital medical staff privileges, (2) economic incentives are lacking, (3) hospital medical staffs and administrators want to provide a full range of services, and (4) some communities insist on having such services readily available.

Authorities, we found, consider regional hospital systems to be an effective way of organizing and using scarce medical skills and facilities and of curbing rising costs. Communities, hospital officials, and physicians, however, have resisted the development of such systems because they want to maintain complete autonomy and to provide each community ready access to health services.

FEDERAL AGENCIES' EFFORTS TO BETTER USE MEDICAL RESOURCES

Until recently Federal agencies planned for acquiring medical resources and delivering health care only in terms of individuals for whom each agency had a primary health care responsibility. Therefore, DOD provided care to active duty military personnel; VA to veterans; and PHS to American seamen, PHS' commissioned corps, and Coast Guard personnel.

However, on June 17, 1977, headquarters representatives of DOD, VA, and HEW met to discuss DOD's plans for acquiring computerized tomography scanners in fiscal years 1977 and 1978 and the impact that these plans would have on the other Federal health care providers. Other purposes of the meeting were:

--To affirm a commitment by the participants to cooperative computerized tomography scanner planning, including coordinated development of criteria and standards. This approach included sharing such services when feasible.

--To affirm a top-level commitment to similar cooperation in planning for all highly specialized services and capital equipment investment.

--To identify contact points in each Federal agency and set the stage for working level contacts.

Following this meeting planning information was exchanged and the feasibility of sharing scanners as well as cardiac catheterization laboratories between DOD and VA was considered. Subsequently, DOD gave VA lists describing the specialty services and medical capabilities at Army, Navy, and Air Force hospitals in the United States. These lists were to be used with VA's list of specialized medical services and programs to help select resources that appear likely for possible cooperative planning and sharing. In addition, PHS indicated its willingness several times to exchange services with other Federal agencies. Subsequently an interagency Federal Health Resources Sharing Committee was created.

An overall agreement (charter) to share medical resources was drafted by DOD, VA, and PHS officials. This charter has recently been approved by all agencies concerned. The approved charter directs the Committee to identify and eliminate obstacles to sharing, to prepare guidelines for sharing

and other cooperative arrangements for the agencies, to recommend actions to be taken when obstacles are not within the authority of the agency heads to resolve, and to establish subcommittees to deal with specific areas of concern.

In addition, DOD and VA regionalization programs have attempted to make better use of the medical resources within their agencies.

DOD'S ARMED FORCES REGIONAL HEALTH CARE SYSTEM

On September 5, 1973, the Deputy Secretary of Defense directed the Secretaries of the Army, Navy, and Air Force to implement the Armed Forces Regional Health Care System. The purpose of the system is to improve the delivery of health care to all DOD beneficiaries by increasing productivity and achieving economies in resources while improving patient/staff satisfaction and insuring that no degradation of quality ensues. The continental United States was divided into 13 military medical regions based on DOD population and the location of specialty treatment facilities.

The Surgeons General of the Army, Navy, and Air Force informed us in September 1976 that under this form of regionalization, the most significant accomplishments to date were the initiation and completion of triservice studies on (1) comparability of health resources between the military services, (2) patient regulation, (3) optical services, and (4) blood programs. However, according to the Surgeons General, more significant than all of these accomplishments was the start of a program of continued contact and information exchange between uniformed medical treatment facility personnel at all levels and in all specialties.

Triservice regionalization continued until December 1976 under the same organizational structure established in September 1973. On December 28, 1976, the Secretary of Defense established a DOD Health Council to provide coordination, standardization, and oversight to DOD's health service programs. The Council was the "central entity" recommended in the Military Health Care Study (see p. 48) to coordinate the planning and allocating of medical resources. The Council is composed of the Assistant Secretary of Defense (Health Affairs) (the chairman), the Surgeon General from each military department, and one representative each from the Joint Chiefs of Staff and the Uniformed Services University of the Health Sciences.

The Council has assumed a responsibility in regard to managing medical resources that has not been previously assigned in DOD. In addition to being concerned over DOD's resources, the Council has established objectives which, if achieved, should help make the best use of all resources--both Federal and non-Federal--in and around the areas served by the numerous military hospitals and clinics. In January 1978, the staff which supported the Council was disbanded because of actions initiated by the Office of the Secretary of Defense.

Since March 1, 1977, all requests for procuring medical equipment with a total cost of $100,000 or more must first be forwarded to the Council for review. Requests must be supported by a cost-benefit analysis and be coordinated with other military and Federal hospitals in the same geographical area. Requests also require specific documentation, including the identification of (1) similar local capabilities in other Federal and civilian facilities and (2) efforts toward seeking interagency sharing agreements. Also, since October 1, 1977, the Council is required to review proposals to establish, close, or expand major medical services or capabilities. This review complements the equipment review process. These actions are similar to the review procedures within the civilian sector under the National Health Planning and Resources Development Act of 1974.

Finally the Council has recognized that the original 13 regions are no longer appropriate. The Council considered various boundary schemes and eventually established nine military medical regions. Redesignation of these boundaries is the first step toward an overall revitalization of the regionalization program and a renewed effort to achieve program objectives.

A DOD directive has been drafted incorporating the policy and concept of operation for the Armed Forces Regional Health Services System. The directive provides guidance in terms of the system's overall objectives, organization, and responsibilities. The draft specifically provides for including VA and PHS representatives in regional review committees' meetings and the establishment, as required in each region, of a Regional Programs Staff and certain standing subcommittees to focus upon specific responsibilities. The approval of this directive is pending until the ultimate reorganization of health affairs in DOD and the role of the Council is resolved.

VA REGIONALIZATION PROGRAM

VA has implemented a regionalized approach for delivering health services by dividing the country into 28 medical districts. The primary objective of regionalization is to improve patient care through the most effective and efficient use of VA medical resources. VA's regionalization concept recognizes that sophisticated, expensive, specialized medical services cannot be provided at each VA facility; however, VA beneficiaries can usually be referred to another VA facility within the medical district to receive the services. Interdistrict referrals occur when needed specialized services are not available within each medical district.

According to VA officials, the regionalization of the VA's Department of Medicine and Surgery continues to be a major departmental policy. It encompasses growing field authority with broadening medical district responsibilities, VA Central Office planning with a medical district focus, and medical district planning and budgetary management to maximize resource use. This approach in each medical district to health care delivery, through a district executive council led by a medical district director, is responsible for assuring the availability of programs with optimum productivity, evaluating and monitoring programs, distributing resources, and planning to meet present and future needs.

In December 1976 regionalization was instituted within VA on a systemwide basis. Subsequently all 28 districts received a consolidated budget for fiscal year 1978 and were responsible for recommending personnel ceilings and the distribution of workloads and resources. In previous years such funding and functions were done on a hospital-by-hospital basis. This revised method of budgeting will require continual internal monitoring and the eventual recommendation for reallocation of resources. This will allow local flexibility to meet the changing requirements of health care delivery in the districts.

According to VA officials, accomplishments under the intra-VA regionalization program include the uniform interpretation and application of policy statements, directives, and reporting procedures; increased use of educational and training opportunities; medical district assessment of program needs; prioritization of resource allocations for equipment, construction, and maintenance projects and programs; realignment of bed services within districts to provide easier and more ready access to services; avoidance of duplication of services; increased intra-VA exchange and use of professional expertise and clinical support

capabilities; and recognition and designation of employees who have met high performance standards.

According to VA's response to the National Academy of Sciences report (see p. 50) a secondary objective of the overall VA regionalization program is to improve the use of medical resources and facilities between VA and community health providers. Under this program, contracts for sharing allow expanded use of community medical resources and allow health institutions in the community to use VA's specialized resources.

INTERAGENCY SHARING

We requested lists from DOD, VA, and PHS headquarters offices of the interagency sharing arrangements each agency had. However, at January 1978, a complete list was not available from every agency. Therefore, though agencies are exchanging services under various interagency arrangements, we will discuss only those arrangements brought to the attention of the Congress in the last 18 months.

The only recurring report made to the Congress on medical resources sharing is an annual report by the Administrator of Veterans Affairs as required by 38 U.S.C. 5057. This report contains only the formalized sharing agreements (38 U.S.C. 5053) under which VA receives or provides services. VA does, however, provide services under the Economy Act.

In VA's fiscal year 1977 annual report on sharing, 93 VA health care facilities were listed as sharing their resources with or using the resources of other Federal and non-Federal health care facilities. Two hundred twenty-five sharing agreements were required for these services to be shared. The total cost of the services exchanged under these agreements amounted to about $16.1 million. Of this, about $6.25 million represented the cost of services furnished by VA and $9.87 million represented the cost of services furnished to VA. However, according to the report, only 4 of the 225 agreements were with other Federal facilities. Under these sharing agreements, services costing only about $9,100 were provided to VA by another Federal agency and services costing only about $17,200 were provided to other Federal agencies by VA.

The only other recent document which cited other medical resources shared between Federal facilities was a December 29, 1976, letter report to the Chairman, Senate Appropriations Committee, from the Assistant Secretary of Defense (Health

Affairs) concerning the feasibility of sharing Federal medical facilities. This letter stated that in calendar year 1975 DOD had allocated an average of 123 beds per day for VA beneficiaries. VA, during the same period, provided an average of 283 beds per day for inpatient care for DOD beneficiaries. An attachment to the letter showed that 166 beds in certain Army, Navy, and Air Force hospitals had been requested by VA for use in fiscal year 1977 for VA beneficiaries. However, we were told by VA's Director, Medical Administration Service, that DOD's allocation of beds for VA beneficiaries are really "phantom beds," which normally are used only in emergencies. Furthermore, an official of DOD's Armed Services Medical Regulating Office said the DOD beneficiaries placed in VA hospitals by that Office are usually active duty personnel who will soon be separated from active duty because of disability or retirement. These beneficiaries would, for the most part, eventually become the primary responsibility of VA and therefore are referred to VA hospitals by DOD before separation and accepted by VA in order to provide continuity of care.

CASE STUDIES OF SELECTED OPPORTUNITIES--

AND RELATED OBSTACLES--TO INTERAGENCY SHARING

Numerous opportunities exist for interagency sharing of medical resources, in addition to those identified in previous GAO reports. (See app. II.) The potential of these opportunities was largely unrealized for various reasons. Obstacles to sharing are the primary focus of these case studies and our study conducted at the request of the Chairman, House Appropriations Committee.

These case studies illustrate inconsistencies within and between agencies in the interpretation of laws and regulations. They do not always provide a clear, understandable and logical reason why sharing did not occur. Rather, they often raise questions, but in our opinion, accurately illustrate the confusion among Federal health facility managers about their authority and responsibility to share. We believe that these examples effectively demonstrate the need for a clear and concise Federal legislative mandate on sharing Federal medical resources and the corresponding need for implementing procedures.

The case studies are presented by the following geographical areas: Seattle-Tacoma, Washington, area; San Francisco, California, area; Los Angeles, California, area; San Diego, California, area; Tucson, Arizona, area; Albuquerque, New Mexico, area; Colorado-Wyoming area; Temple, Texas, area; Tampa, Florida, area; Miami-Key West, Florida, area; Lexington, Kentucky, area; and New England area.

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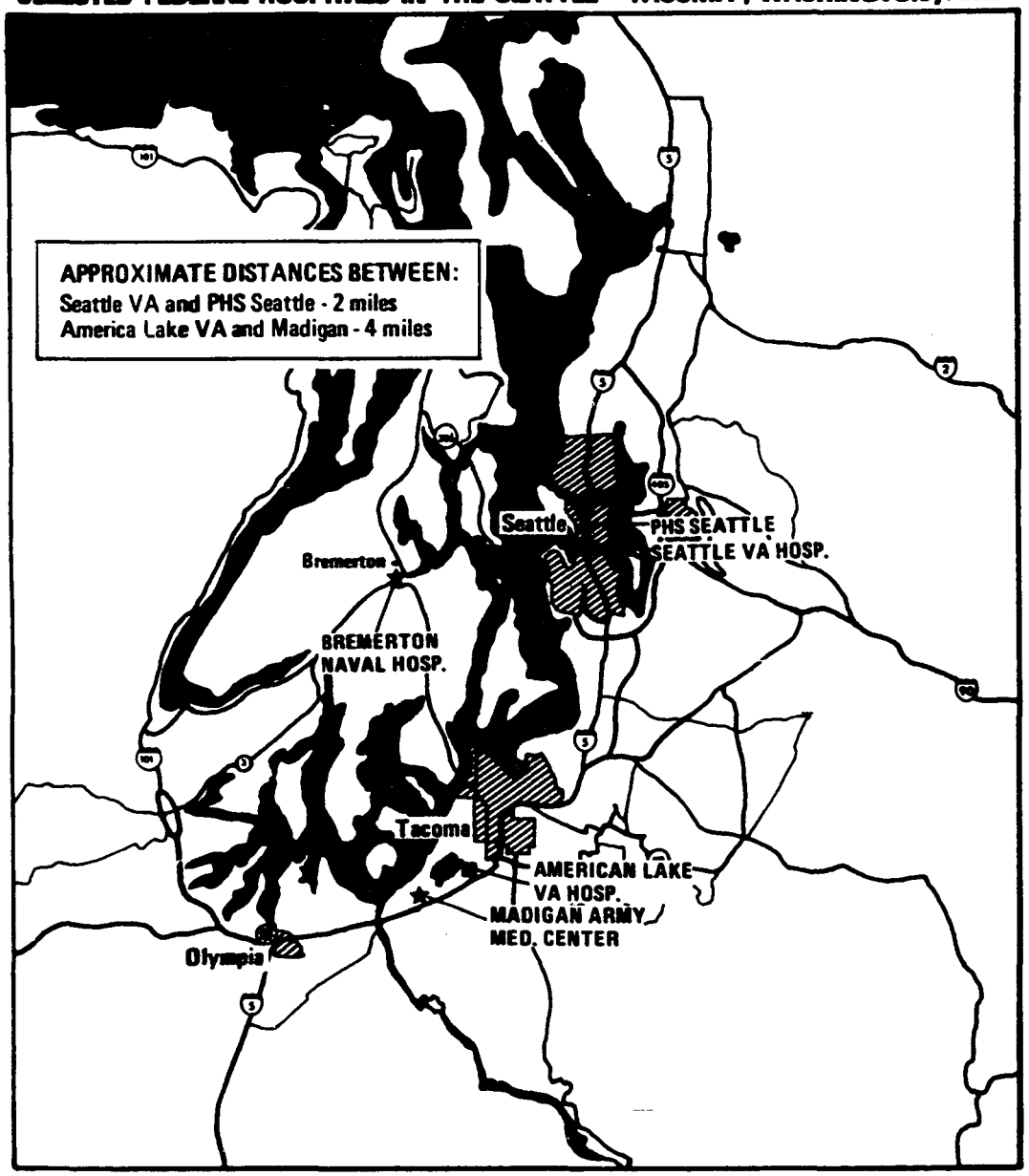
SELECTED FEDERAL HOSPITALS IN THE SEATTLE - TACOMA, WASHINGTON, AREA



CASE STUDY 1

REGULATIONS HINDER SHARING OF PSYCHIATRIC SERVICES BETWEEN ARMY AND VA

Army and VA officials in the Tacoma area believed DOD and VA regulations hindered a sharing arrangement for psychiatric services. Madigan Army Medical Center and VA officials thought that one reason for limited sharing with VA was that not all Army beneficiaries were eligible for treatment in a VA facility. Also VA's sharing authority restricted outpatient psychiatric services from being shared. Thus no psychiatric services were shared, and CHAMPUS was relied on more than necessary even though excess Federal capability existed.

American Lake VA Hospital, Tacoma, entered into a sharing agreement under the Economy Act (31 U.S.C. 686) to provide inpatient psychiatric services for patients referred by Madigan. Under this agreement, effective in November 1975 and extended to September 1977, American Lake agreed to provide 2,700 hospital days of treatment a year at interagency rates for Madigan patients. These services were to be provided with programmed resources. In addition, American Lake officials acknowledged that they could provide up to 100 outpatient visits per month to Madigan with available resources.

However, the agreement permitted only active duty military patients to be referred, since American Lake officials believed that they lacked the authority to treat dependents of active duty or dependents of retired military personnel. Furthermore, Army regulations do not authorize treating military dependents in a VA hospital. According to American Lake officials, retired military personnel would be eligible for treatment as veterans.

As of June 1977 Madigan had not used any services covered under the agreement or any other psychiatric services available at American Lake. According to Madigan's Chief of Psychiatry, this occurred because Madigan can provide psychiatric care to active duty personnel. He stated that the agreement had been developed as a contingency for any increased workload. On the other hand, Madigan did not have sufficient staff to provide psychiatric care to all military dependents. Since American Lake and Madigan officials believed that VA could not provide care to military dependents, patients sought care from civilian sources under CHAMPUS.

The total cost of psychiatric care provided under CHAMPUS in the Seattle-Tacoma vicinity (zip code areas) for calendar year 1976 was about $500,000. While data is not available to show precisely how much savings could have resulted in treating these patients at American Lake, up to 2,700 inpatient days and 1,200 outpatient visits a year could be provided with available resources at American Lake.

The Chief of Staff at American Lake VA stated that VA could have provided outpatient services for about 56 percent of the normal charge under CHAMPUS. In addition, the Chief of Psychiatry at Madigan stated that treating military dependents at American Lake would generally be more convenient to military families because of its proximity.

Since Madigan and American Lake officials believed VA could not treat military dependents, we explored the reasons why active duty personnel had not been sent to American Lake under the sharing agreement, making it possible for Madigan to provide psychiatric services to more military dependents. Madigan officials informed us that this was not a workable alternative because Army regulations state that active duty military have first priority for treatment in an Army hospital.

Even if military dependents could be treated in a VA facility, current budgetary procedures do not provide adequate incentives for the Army to enter into such an agreement, according to Madigan officials. This lack of incentive stemmed from the fact that local officials believed that care provided under CHAMPUS was restricted to civilian providers. In any case the cost for such care is not a part of the Army's budget. CHAMPUS payments are covered under a separate DOD appropriation. However, if the Army referred military dependents for treatment in a VA facility, the Army would have to reimburse VA from its health care budget.

According to American Lake VA officials, 38 U.S.C. 5053 is the only authority under which American Lake could have provided care to all DOD beneficiaries. However, this authority permits sharing of only "specialized medical resources," which are defined as medical resources that are either costly, scarce, or can be fully used only through mutual use. VA's Chief Medical Director has authority to define what constitutes a specialized medical resource and has determined that outpatient psychiatric services are not specialized medical resources.

CASE STUDY 2

INFLEXIBLE INTERAGENCY REIMBURSEMENT RATES HINDER SHARING

Renal dialysis

The Seattle VA Hospital had a contract with a private hospital to perform renal dialysis for veterans in Tacoma, about 35 miles from Seattle VA but only a few miles from Madigan. The contract called for 906 treatments a year at $133 per treatment. During calendar year 1976, the cost was about $120,000.

At the time of our review, Madigan's renal dialysis unit was treating two patients. Madigan had the equipment and personnel to include VA patients in its dialysis program if its renal dialysis ward were remodeled. Remodeling would be necessary to provide for the optimum use of present equipment and staff. It would cost about $15,000 and was being planned. Madigan's Chief of Renal Dialysis and Comptroller stated that they would be willing to treat VA's patients if Madigan could be adquately reimbursed.

Army regulations require that Madigan charge as well as pay interagency rates when sharing inpatient and outpatient medical services with another Federal facility. Interagency rates are set by each agency and approved by OMB. The interagency rate in fiscal year 1977 for inpatient care in a DOD facility was $168 a day, and the outpatient rate was $20 a visit. Madigan officials stated that they were not aware of any authority that allows for variations from the interagency rates for medical procedures directly involving the patient.

The Comptroller stated that the interagency outpatient reimbursement rate of $20 is inadequate. He also stated that Madigan does not directly receive any of this amount back from Army headquarters. He believed Madigan would, as a minimum, need to be reimbursed for all renal dialysis supplies, including those used by the two Madigan patients. He stated this would cover Madigan's true marginal costs in providing the services.

Seattle VA's Chief of Renal Dialysis said expendable renal dialysis supplies cost about $60 a treatment. However, Army regulations required that Madigan not charge VA more than the above interagency rates. Renal dialysis requires 4 to 9 hours of treatment and, since the patient

is not admitted to the hospital, treatment is usually classified as outpatient treatment. In addition, if Madigan charged the inpatient rate, sharing would not be advantageous to VA since VA's current contract rate is $133 per treatment. But if Madigan could be reimbursed for supplies, VA's costs would be more than cut in half, from $133 a treatment to about $60.

We also inquired whether VA could purchase the supplies and send them to Madigan to be used in treating VA patients. A Madigan official informed us he was unaware of any Army regulations that would permit such an arrangement.

Radiology

Madigan had about 50 percent of its authorized radiologists. On the other hand, nearby American Lake VA Hospital employed a part-time radiologist under a personal services contract. Both American Lake and Madigan were receptive to American Lake's obtaining a full-time radiologist to share with Madigan in exchange for some needed medical services.

Madigan and American Lake officials were unsure how to pursue this type of arrangement in view of regulation complexities. An American Lake official believed a full-time radiologist position would have to be justified to VA headquarters on the basis of VA patient workload. Madigan officials believed they would have to pay and be reimbursed interagency rates in sharing with American Lake. Because of the uncertainties on both sides concerning the correct way to proceed on this matter, the services of a full-time radiologist were not obtained.

CASE STUDY 3

CHAMPUS PROCEDURES DO NOT ENCOURAGE OPTIMAL USE OF FEDERAL FACILITIES

Dependents of military personnel, military retirees and their dependents, and dependents of deceased military members may receive medical care either in their designated medical system or in a civilian medical facility under CHAMPUS. Generally, for inpatient treatment under CHAMPUS, these patients must obtain a certificate stating that needed care is unavailable in a uniformed service facility within a 40-mile radius. A similar certificate is not required for outpatient care because such services are not required to be performed in a uniformed service facility.

We obtained data from CHAMPUS headquarters on the types of medical services being provided to CHAMPUS patients in most of western Washington. To determine if these services could have been provided by local Federal facilities, we compared these procedures with those at facilities having some unused capacity. While this analysis did not allow us to determine how many of these CHAMPUS patients could have been treated in Federal facilities, it indicated care is being obtained under CHAMPUS despite the unused capacity of nearby Federal facilities.

For example, Seattle VA, Seattle PHS, and Madigan Army Medical Center all had some excess capacity in their nuclear medicine departments. However, projections from the CHAMPUS data disclosed that about $25,000 of nuclear medicine diagnostic procedures had been procured in selected western Washington zip code areas during calendar year 1976. Similarly CHAMPUS paid an estimated $6,500 for electroencephalograms even though three hospitals reviewed acknowledged excess capacity. In a previous case study (see p. 67), almost $500,000 of psychiatric care was also provided through CHAMPUS in the Seattle-Tacoma zip code areas, even though a VA psychiatric facility in the area had available capability.

Furthermore, PHS regulations do not allow PHS to contract for hospitalization of CHAMPUS beneficiaries in a non-PHS hospital. As a result, PHS cannot take advantage of orthopedic surgery at the nearby VA hospital.

Between February and May 1977, 13 PHS patients requiring nonemergency orthopedic surgery were referred to a civilian facility under CHAMPUS. The Seattle VA Hospital, 2 miles

from PHS, performs orthopedic surgery. The Chief of Staff at the VA hospital stated that VA could have absorbed some of these PHS patients into their orthopedic surgery schedule. In addition, he stated the VA hospital could have provided sufficient postoperative care for them until they could be transferred to PHS and that the hospital needs to be reimbursed a sufficient amount to cover the costs of the services.

CASE STUDY 4

BUDGETARY CONSTRAINTS LIMIT SHARING OPPORTUNITIES

VA and DOD radiation therapy

In VA's Medical District No. 28, there are nine VA facilities in Washington, Oregon, and Idaho. None have in-house capability for radiation therapy used in treating cancer. VA patients in Seattle and Portland have received radiation therapy at nearby medical schools. Other district facilities transferred 54 patients to the Martinez VA Hospital near San Francisco during calendar year 1976.

In January 1977 the Chiefs of Staff at VA hospitals within Medical District No. 28 recognized the need to obtain this service from a new source within the district. Therefore, the district attempted to obtain this service from Madigan Army Medical Center, the only Federal facility with radiation therapy capability within the district. The Deputy Commander at Madigan said Madigan had equipment to accommodate non-DOD patients, but not the staffing. He therefore responded to VA's request by stating:

> "Due to present staffing limitations at this facility, to include radiation therapy technicians and laboratory technicians, I must state, with regret, that we cannot meet your requests. Additionally, our next higher headquarters has not assigned us the mission of supporting the Veterans Administration in this matter." (Emphasis added.)

As a result of the above response, accompanied with an increased need to obtain a cost-favorable source for radiation therapy within the district, the VA's Medical District No. 28 Director informed us that VA is considering a long-range plan to develop the capability for in-house radiation therapy requiring an equipment cost alone of $500,000.

VA and PHS angiogram procedures

Another element that was a budgetary constraint to sharing is VA's procedure which restricts sharing to programmed resources. This procedure resulted in less than optimum use of angiogram equipment.

Both Seattle VA and PHS have angiogram units (sophisticated X-ray equipment used for diagnostic purposes). Procedures are performed by injecting dye and chemicals into selected areas of the body and using the angiogram (X-ray) equipment to film the areas under examination. Seattle VA's modern angiogram unit can perform very complex angiographic procedures. VA's equipment cost about $500,000 while PHS' equipment cost $250,000. VA's equipment was being used at 80 percent of capacity, based on 8 use-hours a day. In March 1977 PHS installed its own unit. The equipment was originally purchased in 1972 but was not installed until 5 years later due to lack of space-remodeling funds. Remodeling and installation cost about $30,000.

PHS headquarters officials said that the PHS equipment was purchased to be used for angiograms and a variety of other radiographic diagnostic purposes. PHS expects to use the equipment about 8 to 13 hours a week for angiograms and a substantial number of additional hours for other radiographic diagnostic procedures. PHS believes that angiography is an essential service in any modern general hospital if adequate diagnostic services are to be provided for acutely ill patients and if patients can not normally be transferred to other facilities for angiograms.

Nevertheless, between November 1975 and March 1976, VA performed most of PHS' angiograms. In May 1976 PHS' need for angiograms increased, which caused scheduling disruptions at VA. As a result, VA imposed procedural guidelines which restricted PHS' use of VA's specialized X-ray procedures to three PHS patients per week. PHS patients that could not receive angiographic services at VA were sent to civilian hospitals. According to PHS' Chief of Radiology, this represented about two procedures a week. The Chief of Radiology, VA, told us that VA could have performed the two additional tests per week during other than normal working hours.

However, this alternative was not supported by VA or pursued by PHS because sharing procedures restricted sharing to resources that have been justified on the basis of veterans' care but which were not being used to their maximum extent during normal working hours. Therefore, Seattle VA believed it lacked budgetary authority to expand its staffing resources solely to serve PHS' needs.

We were told in May 1977 that Seattle VA was procuring an additional angiogram unit to be used in conjunction with VA's cardiac catherization laboratory. This equipment cost an estimated $333,000. Seattle VA officials said this equipment could also be used for PHS angiogram procedures. However, availability of staffing would still be a problem if PHS' needs could not be met during normal working hours.

CASE STUDY 5

EMPHASIS ON INTRAAGENCY PLANNING RESTRICTS OPTIMUM USE OF FEDERAL HEALTH CARE RESOURCES

Electron microscope

Madigan Army Medical Center's pathology department requested about $60,000 worth of new electron microscope equipment even though Seattle VA's equipment could absorb the additional workload. No attempts were made to determine the capacity of other local Federal facilities.

Madigan has electron microscope capability, which is used to study tissue specimens for diagnostic purposes. Madigan officials told us that during 1975 and 1976 the equipment had been used only a few hours a week. However, Madigan's Chief of Pathology stated that because the equipment is aging, he has requested it to be replaced at a cost of about $60,000.

Seattle VA has an electron microscope that cost $91,000 and is operated about 4 hours a day. Seattle VA is doing electromicroscopy procedures for PHS at no charge because of the small increase in time and resources required to process additional procedures. Furthermore the Chief of the Electron Microscope Section at Seattle VA stated that he would like to do Madigan's procedures because of the need for additional work to support Seattle VA's training programs. Seattle VA is willing, he said, to do these tests at no cost to Madigan.

Echocardiogram units

Four Federal facilities in the Seattle-Tacoma area had echocardiogram equipment;,none was fully used based on a 40-hour workweek. Echocardiograms are used as an aid for locating and diagnosing cardiovascular problems. The equipment is normally operated by a technican, and each procedure takes about 30 minutes to 1 hour (or, conservatively, about 40 procedures per week). The following table shows that echocardiogram equipment at Federal facilities was not being fully used and that two facilities plan to upgrade present capacity.

Federal facility	Estimated hours of use per week	Plan to procure new equipment	Cost of new equipment
Seattle VA	30	Yes	$13,020
Madigan Army Medical Center	12-15	Yes	44,500
American Lake VA	2-3	No	
PHS Seattle	5-9	No	

Sharing between American Lake and Madigan would eliminate Madigan's need to purchase a new echocardiogram unit. Furthermore, according to the technican at American Lake, if the two facilities shared the equipment, American Lake's could be upgraded for about $23,000 versus $44,500, the cost of a new unit at Madigan.

Electroencephalogram units

The electroencephalogram units at Madigan and American Lake are underused. Interagency coordination might have prevented acquiring some of this duplicate equipment.

American Lake has electroencephalogram equipment, which detects and records brain waves, but does not have a technican to operate it. Consequently, at the time of our review, it was sending patients about 45 miles to Seattle VA. Three patients were sent during a 5-week study period.

Madigan, 4 miles from American Lake, has two electroencephalogram units and was planning to add another unit. Equipment costs range from $8,000 to $15,000. The new unit was expected to increase the workload capacity. The Chief of Madigan's electroencephalogram unit stated that it is doing some procedures for American Lake and could take on additional VA workload if asked.

Nuclear medicine scan units

Seattle VA, Seattle PHS, and Madigan all have excess nuclear medicine capability. Seattle VA has three units costing a total of about $240,000, and is doing some procedures for American Lake. During the first half of fiscal year 1977, Seattle was operating below VA's minimum utilization standards for nuclear medicine capability. Seattle is doing 6 to 8 procedures daily but has a maximum capability of 18 procedures daily. Madigan has two nuclear medicine

units each costing between $125,000 and $150,000. It has some excess capability and is doing about 45 scans per month for American Lake on an informal basis.

In June 1976 the local VA regionalization council met to discuss the feasibility of developing a nuclear medicine laboratory at American Lake. In June 1977, $270,000 was approved by VA's Central Office for this project which had high priority for implementation as part of VA regionalization efforts. The excess capacity of the other three facilities was not adequately considered.

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In commenting on this case study, PHS headquarters officials told us that restrictions on the purchase of equipment should be applied to areas of high-cost technology where serious questions of cost effectiveness arise. In their opinion, all the examples cited in the case study are necessary diagnostic equipment in a modern general hospital which operates as a regional medical center, such as each of the PHS hospitals. As such, PHS believes that they are indispensible to providing basic medical services to patients in that hospital's region. However, they agree that such services could be shared.

CASE STUDY 6

REGULATIONS RESTRICT PATIENT MOVEMENT BETWEEN FEDERAL FACILITIES

VA and DOD regulations required some patients to be transported to hospitals outside the area so they could be treated within the same agency. Some patients were sent several hundred miles for treatment even though a nearby Federal facility had the capability. The restrictions may result in less than optimal patient care and in underuse of resources. In addition, patients may be needlessly separated from their families for long periods.

VA spinal cord injury patients

Seattle VA transported an estimated 19 spinal cord injury patients to California during a year's time, even though PHS Seattle has a spinal cord injury center. The VA and PHS hospitals are 2 miles apart. Further, Seattle VA is planning to construct a spinal cord injury center without considering sharing PHS capability.

A Seattle VA official said sharing could not be considered because of regulation restrictions. The regulation states, in part:

> "A patient hospitalized by the VA may develop a need for treatment which the hospital is not staffed and equipped to perform * * *. A transfer to a non VA hospital is restricted to those patients developing a bona fide medical emergency which precludes moving the patient to another VA hospital."

In one instance, a patient may not have received optimal care and local Federal facilities were not fully used. A Coast Guard member injured on active duty received spinal cord treatment from a local community hospital in Miami, Florida, at a cost of over $13,000. The Miami PHS clinic responsible for Coast Guard beneficiaries had no capability to treat spinal cord injuries; hence the referral to the community facility. However, Miami VA's spinal cord injury center could easily have treated the beneficiary within existing capacity. VA's charges--using interagency reimbursement rates of $116 an inpatient day--would have been about $7,000 for the same period, a savings of over $6,000. PHS did not consider contacting VA for the services, however.

After the initial treatment in Miami, the patient requested to be transferred to a Federal facility near his

family in the Seattle area. Before discharge from active duty, he was admitted to Seattle VA. Seattle VA was selected because (1) it was near his home and (2) DOD regulations, applicable for all uniformed service beneficiaries, require that servicemen with permanent physical disabilities be discharged to VA for rehabilitation. Fifteen days after arrival at Seattle VA, he was officially discharged from the Coast Guard and became a VA beneficiary.

Before and after the patient was admitted to Seattle VA, he was told he needed further spinal cord injury treatment. However, in Seattle he was informed that he would have to go to VA spinal cord injury center in California. He refused to go because he did not want to leave his family. A Seattle VA official stated that the VA regulation noted above had precluded the patient from being transferred to a non-VA facility. He further informed us that since the patient was in the hospital for rehabilitation, he could not be classified as an emergency case, which precluded movement to a non-VA hospital.

As a result of this restriction, the patient's VA physician told us he looked into the possibility of the patient being discharged and then admitted to the nearby spinal cord injury center at PHS. He stated PHS informed him that, while PHS may have room for another spinal cord injury patient, PHS could not admit the patient because he was not then an eligible PHS beneficiary although he had been. As a result, the patient elected to receive limited care at VA because VA could not transfer him to PHS and PHS could not accept him unless VA effected a transfer.

PHS headquarters officials initiated corrective action after this particular incident was brought to their attention to insure that such an incident does not occur again.

Navy drug abuse patients

Under DOD procedures, if active duty Navy personnel need specialized care not available at the Navy Regional Medical Center, Bremerton, Washington, they can be referred to Madigan. However, if Madigan cannot provide the specialty, the patient is referred directly to a Navy hospital outside the region. In calendar year 1976, Bremerton sent 16 drug abuse patients to the Navy treatment center in California because Madigan did not have the capability to provide care for these patients. No attempts were made to seek treatment at nearby American Lake VA, which specializes in drug abuse and could have treated these patients within programmed resources.

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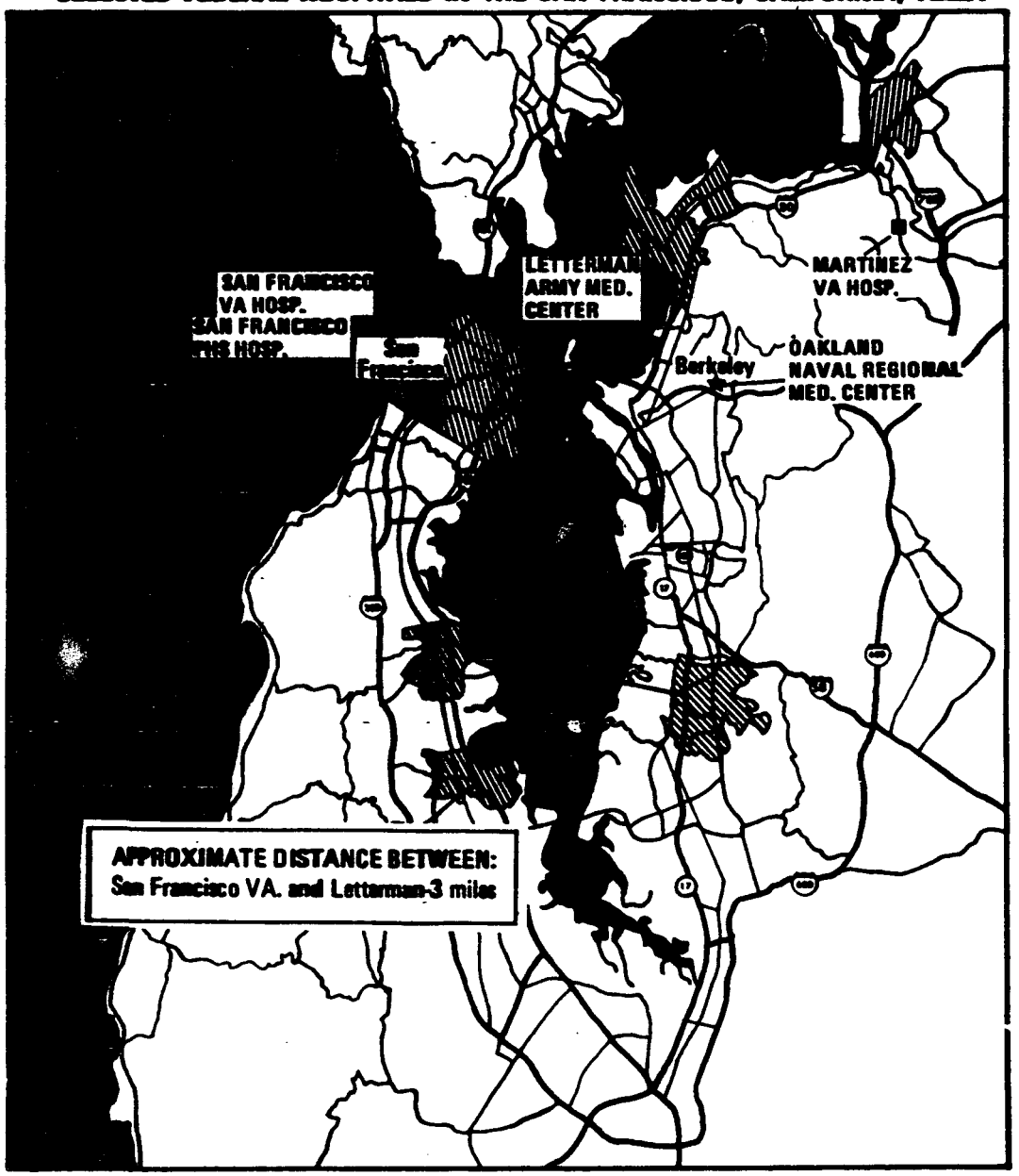
SELECTED FEDERAL HOSPITALS IN THE SAN FRANCISCO, CALIFORNIA, AREA



CASE STUDY 7

LACK OF GUIDANCE PREVENTS SHARING BETWEEN VA AND DOD HOSPITALS

For 1-1/2 years San Francisco area VA and DOD officials negotiated unsuccessfully to share medical services between Federal hospitals. Many obstacles were cited, but the primary obstacle was a lack of DOD guidance on interagency sharing. Through individual initiative some progress toward VA-DOD sharing had been made, but officials were concerned that if precise guidance was not provided and other obstacles removed, it was doubtful that any great amount of sharing would occur.

VA's first formal contact with DOD occurred in March 1976, when VA proposed a sharing program beginning with DOD's radiation therapy capability. VA become interested in sharing with DOD hospitals when it found that all three major DOD facilities in the area--David Grant Medical Center, Travis Air Force Base; Letterman Army Medical Center; and the Naval Regional Medical Center, Oakland--had extensive radiation therapy capability. Most of VA's radiation therapy was being performed at the University of California Medical Center, San Francisco, and Martinez VA Hospital, the only VA hospital in the area with radiation therapy capability. Martinez VA's radiation therapy facilities, however, would have needed major upgrading to handle the entire VA workload. VA officials thought that sharing DOD's radiation therapy facilities might relieve some of the load without large VA expenditures and might save some money being spent at the university.

San Francisco VA officials estimated about $208,000 was being spent annually at the university for VA patient radiation therapy. The university was paid for these services from San Francisco VA's own operating budget, so San Francisco VA had an incentive to save money. Although rates had not been negotiated with nearby Letterman, VA officials expected them to be substantially lower than those of the university. In fact, a San Francisco VA official estimated about half the annual expenditures could be saved by shifting part of the workload to Letterman.

As a result of the March 1976 contact with the military, VA, at a meeting with the DOD triservice regionalization group on June 25, 1976, proposed sharing of facilities and services between VA and DOD. Initially DOD treatment of radiation therapy patients was to be emphasized.

According to VA officials, the DOD participants were friendly and attentive, but not very enthusiastic. DOD officials felt that the VA presentation had been an initial exploratory step toward a mutually beneficial exchange of information and services. DOD did not make any direct commitments, however, primarily because guidance was not available on how to proceed with interagency proposals.

Consequently, the Northern California Military Medical Region requested guidance in a July 1976 report to the regionalization coordinating body in Washington, D.C.--the Military Medical Regional Coordinating Office (MMRCO). The report stated:

> "We expect to continue exploration and exchange of information with the VA: however, guidance from the MMRCO would be helpful in establishing procedures prior to exchanging or providing services." (Emphasis added.)

No guidance had been provided as of August 1977, over 13 months later. As a result, VA and DOD had not exchanged any services. In the interim VA was invited to attend DOD professional counterpart meetings and was included on a list of area Federal medical capabilities, but these achievements--resulting from extensive individual initiatives --were the extent of interagency activities. Letterman officials believed an agreement could have been worked out if proper guidance and procedures from DOD had been available and other obstacles--including reimbursement constraints--had been eliminated.

Officials from all three DOD hospitals cited two major obstacles to sharing with VA: (1) the lack of guidance and (2) a lack of incentives to share. The officials believed that to give the military an incentive to share, the providing hospitals must be directly reimbursed. According to these officials, headquarters collect payments for inpatient and outpatient services. However, no inpatient or outpatient funds collected are returned to the hospital to help defray costs of additional supplies or staff.

VA and DOD officials believed potential for several sharing agreements existed that could be beneficial, but probably not much would occur until sharing procedures are clarified and the reimbursement obstacles eliminated. Among the sharing opportunities mentioned were:

--Radiation therapy. In addition to the San Francisco VA/Letterman example, Livermore and Martinez VA

Hospitals could use either David Grant Medical Center or the Naval Regional Medical Center, Oakland.

--Dermatology, rehabilitation, and physical medicine services. San Francisco VA could provide these services to military patients.

--Renal dialysis. Letterman could provide this service to other Federal agencies.

--Biomedical engineering support. This service could be shared between VA, DOD, and PHS.

--Laboratory services. Such services could be shared between VA, DOD, and PHS depending on each laboratory's capabilities.

A VA official told us that any needed service at Federal facilities should be shared. He believed no constraints should exist when the Government and all Federal patients would benefit.

VA officials described certain other obstacles to interagency sharing and offered these suggestions to overcome them.

1. VA has authority to share services with DOD under 38 U.S.C. 5053 on a full cost reimbursement basis. A VA official told us, however, that DOD usually talks about reimbursement in terms of intergency rates, not full cost. VA needs to be reimbursed under a sharing agreement to have funds collected revert to the providing hospital. Without the local reimbursement, no incentive exists to share services. VA officials feel a standard reimbursement mechanism is needed, with funds collected remaining at the providing level.

2. Some patients are restricted from being treated in VA facilities. For example, VA cannot routinely treat DOD dependents without a 38 U.S.C. 5053 sharing agreement. One legal entitlement allowing all Federal beneficiaries to be treated in VA, DOD, and PHS hospitals with the necessary facilities and capabilities is needed.

3. No legal justification exists for spending money at a VA hospital to care for other Federal beneficiaries. Funds collected from other Federal agencies should be used to provide supplies, increase staffs, and upgrade equipment when excess

capabilities exist. Duplication and underuse of services and facilities would subsequently be reduced.

4. VA's Central Office has been overly restrictive in interpreting what constitutes a specialized medical resource and therefore restricts eligibility for sharing under 38 U.S.C. 5053.

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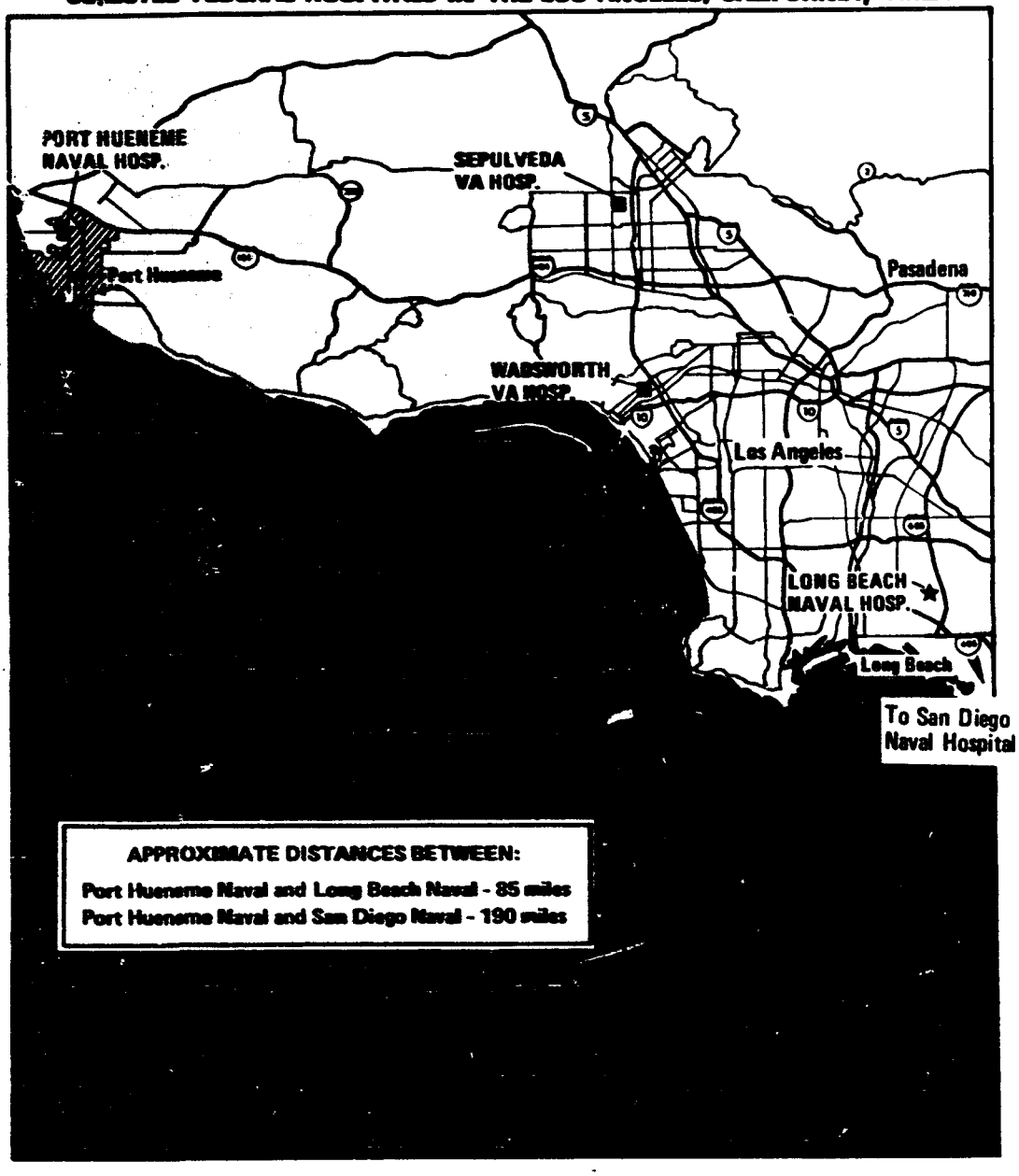
SELECTED FEDERAL HOSPITALS IN THE LOS ANGELES, CALIFORNIA, AREA



CASE STUDY 8

UNANSWERED QUESTIONS PRECLUDE VA FROM SHARING WITH NAVY

VA was willing and able to provide some medical services to Navy beneficiaries under a formal sharing agreement, but doubted that any sharing would occur without clarifying guidance from VA and Navy headquarters.

Because the Naval Hospital, Port Hueneme, California, was not staffed to provide the full range of needed medical services, the possibilities of obtaining specialized services from other Federal facilities in the area were explored. Navy contacted VA Medical District No. 26 officials in the Los Angeles area and asked whether Navy patients could be referred for sophisticated specialties like neurology; urology; ear, nose, and throat; and ophthalmology. Navy believed these services were available at two large VA hospitals--Sepulveda and Wadsworth--in the general area.

Port Hueneme usually obtained these services at the Long Beach Naval Hospital for active duty patients and under CHAMPUS for retirees and dependents, but problems had developed. Long Beach had its own workload limitations and traveltime and distance often precluded quick medical disposition, according to Port Hueneme officials. Also, CHAMPUS patients were finding it increasingly difficult to locate civilian physicians willing to provide service at the CHAMPUS authorized fee schedule. Thus, Navy wanted to use VA as a referral source for all beneficiary categories, even though it believed VA's law prohibited retirees and dependents from being treated.

VA responded to Navy's request by stating that Navy's beneficiaries could probably be treated routinely at the Sepulveda and Wadsworth VA Hospitals if (1) a sharing agreement (under 38 U.S.C. 5053) could be established and (2) the care would be furnished on a space available basis to be determined by the affected VA hospitals.

VA also identified several problems which it felt would have to be resolved before any sharing could begin.

1. VA would need the formal sharing agreement under 38 U.S.C. 5053 for reimbursements to revert to providing hospitals. A VA official said Navy did not know whether it could participate in a sharing agreement; Navy appeared to want payment at

standard interagency rates with fund transfers between Navy and VA headquarters. VA, however, did not want interagency fund transfers because reimbursements would be retained at headquarters. Consequently, no incentive whatsoever existed for VA to do any work for others without a sharing agreement. At least with a sharing agreement, the VA providing hospitals would have a chance at being reimbursed, if VA's Central Office allowed it.

2. According to a VA official, VA's Central Office wanted Navy to answer the following questions before any type of agreement to treat Navy beneficiaries would be approved: Would VA or Navy fill prescriptions written by a VA physician? Would VA or Navy furnish eyeglasses for Navy referrals? Would recommended hospitalization resulting from a Navy outpatient referral be provided by VA or Navy? These and other services which might result from Navy outpatient referrals might cost VA a lot more money than the original care.

3. Active duty military and persons treated under sharing agreements have the lowest priority for VA care. Therefore, VA believed that a Navy patient could get "bumped" by a higher priority VA patient even while the Navy beneficiary was at the hospital waiting for an appointment. As a result, VA felt that few, if any, Navy beneficiaries would even be seen at a VA hospital under current conditions.

At Port Hueneme we were told Navy had also identified several obstacles to sharing with VA, including reimbursement questions and VA's apparent restrictions on Navy beneficiaries.

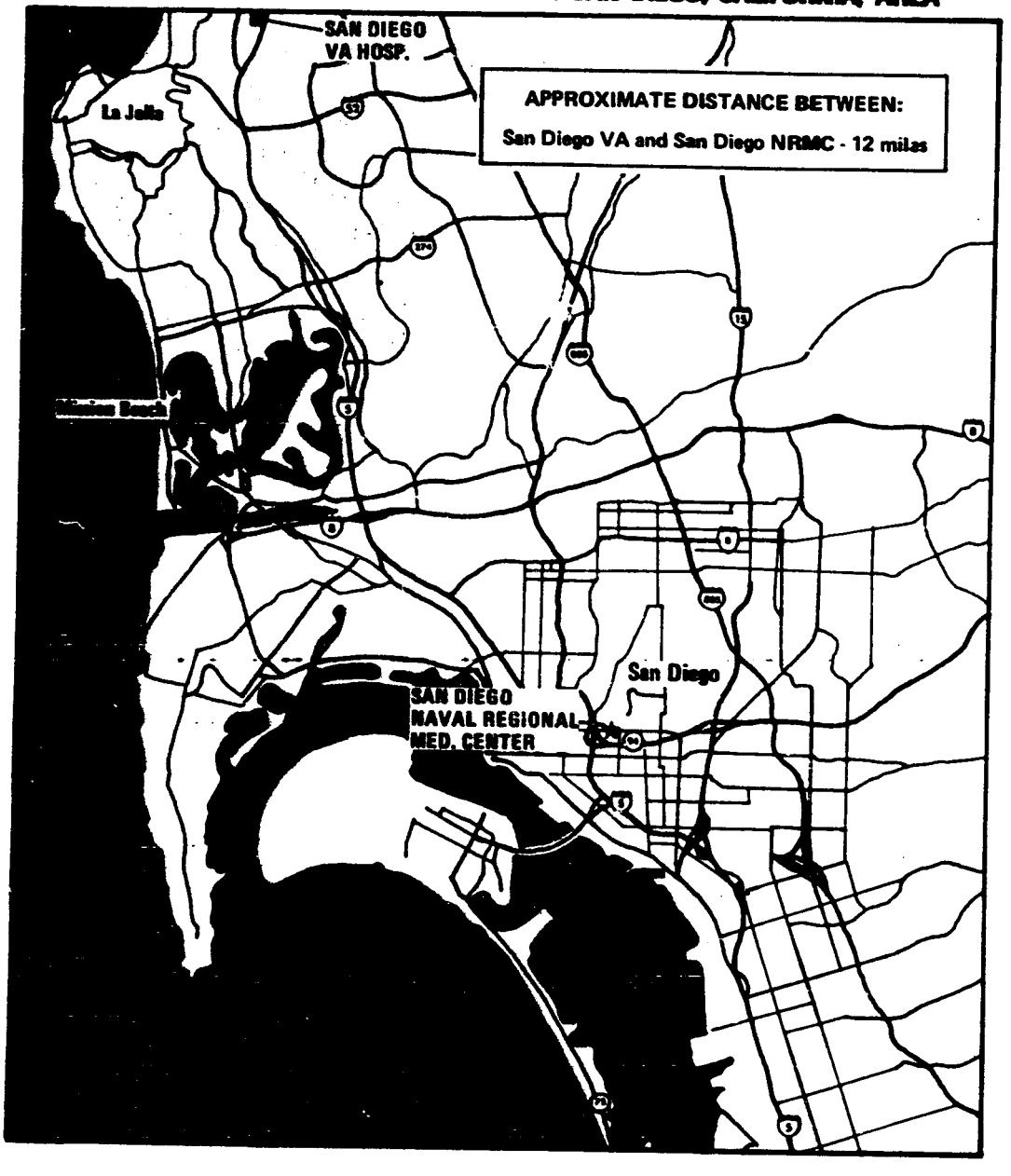
Port Hueneme officials told us that Navy's interagency reimbursement system requires billing and collecting at headquarters level using interagency rates. Port Hueneme would not become involved with billing or collecting, and evidently no mechanism exists for agencies to reimburse each other locally. The officials believed this would present a problem if VA wanted reimbursement any other way besides the headquarters fund transfer. When we visited Port Hueneme, VA and Navy had not discussed payment mechanisms but VA had mentioned needing a sharing agreement using full costs. Navy officials were also uncertain whether they could enter into a VA sharing agreement.

We asked whether Port Hueneme could reimburse VA from hospital supplemental funds used to pay community physicians and hospitals for services beyond Navy's capabilities. The officials did not know the answer and had no experience on which to draw. They subsequently contacted Navy's Bureau of Medicine and Surgery in Washington, D.C., and were told no procedures existed for Navy to pay VA from supplemental funds.

Port Hueneme officials were also concerned about VA's regulations restricting Navy patients to the lowest priority. They believed all Navy patients should be treated equally with other Federal beneficiaries going to VA hospitals. Moreover, they felt that priorities among Federal agencies should be structured to provide for maximum sharing regardless of what type Federal beneficiary was involved.

APPENDIX IV

SELECTED FEDERAL HOSPITALS IN THE SAN DIEGO, CALIFORNIA, AREA



CASE STUDY 9

LACK OF ACCEPTABLE REIMBURSEMENT RATE PREVENTS JOINT VA/NAVY USE OF EQUIPMENT

For the past several years, the San Diego Naval Hospital had referred patients to a community facility for argon laser treatment of diabetic eye disease. The community facility charged $50 for each new patient with no additional charge for subsequent treatments--usually at least six--on the same patient.

A Navy physician told us that several problems had developed with using the community laser. The most serious involved difficulties in scheduling appointments for Navy personnel because of heavy demand and waiting time--as long as 3 weeks--once the appointments were made. The physician stated that some Navy patients had actually suffered during the waiting period and some patients' vision had deteriorated while waiting for an appointment. These undesirable conditions led to a search for an alternate means of treatment, and subsequent negotiations with San Diego VA, which had an acceptable laser unit.

In a letter dated October 30, 1975, the Commander of the Naval Hospital asked VA for permission to use the laser one-half day each week. San Diego VA's response was enthusiastic and it offered to let Navy use the laser at no cost twice a week. However, in subsequent discussions with VA's Central Office, San Diego VA officials were told that some sort of fee was needed and that it would be highly unlikely that any no-fee contract would ever be approved. San Diego VA personnel were very surprised by this opinion, because there would have been no real local costs. The laser was used for research, and Navy was going to use it on off-time. In a San Diego VA official's opinion, a fee was not needed.

Discussions over what fee to charge took several months, and the final VA proposal was unacceptable to the Navy. San Diego VA officials felt that $25 for each patient without cost for subsequent treatments on the same patient would be fair. VA's Central Office, however, stated that although San Diego VA had justified the $25 patient fee, a more appropriate rate would be the $39 interagency rate specified for an outpatient visit. The $39 was to be charged for each treatment, while Navy's price in the community was an initial $50 charge with no subsequent charges for additional treatment.

According to a Navy official, the lengthy negotiations were very frustrating. Because an equitable charge could not be established, Navy ordered its own laser at a cost of $30,000. A Navy official told us that if negotiations with VA had been successful, Navy probably would not have had to purchase its own laser. At any rate sharing would certainly have been tried before purchase was considered.

A San Diego VA official told us an additional problem was a lack of guidance on what type of agreement to use. For example, after Navy's October 1975 request to use the laser and while negotiations over an acceptable charge continued, San Diego VA put together a "Mutual Use of Medical Resources Provided by a Veterans Administration Hospital" contract (sharing agreement) between San Diego VA and the Naval Hospital. It was submitted to VA's Central Office in January 1976. In March 1976 VA's Central Office disapproved the proposed agreement. Several problems the Central Office had with the agreement included (1) no cost was stated, (2) the title should have been "Interagency Use of Medical Resources" rather than "Mutual Use * * *," and (3) the wrong authority to contract with Navy had been cited.

A San Diego VA official said the experience with the Navy showed there is no standard simple method for sharing medical resources between VA and DOD. He felt frustrated by the experience and believed that interagency sharing procedures should be clarified and simplified.

CASE STUDY 10

REIMBURSEMENT PROBLEMS HAMPER VA AND NAVY SHARING A CATHETERIZATION LABORATORY

The VA and Naval Hospitals in San Diego attempted to share VA's cardiac catheterization laboratory but met with limited success. Several problems emerged, including complicated and unclear interagency sharing authorities, reimbursement questions, and lack of incentives to share.

Physicians at the San Diego Naval Hospital needed an alternative source of providing cardiac catheterizations to Navy beneficiaries, and pursued negotiations with San Diego VA, which had an acceptable laboratory. Navy estimated about 700 patients would be catheterized in its laboratory during fiscal year 1976, more than the maximum a single laboratory could handle in a year. On the other hand, VA's laboratory was catheterizing about 150 patients a year at the time. Navy had alternatives to approaching VA--e.g., build a second catheterization laboratory, request area referral military hospitals to send their patients elsewhere, or refer retired and dependent patients to CHAMPUS--but wanted to explore the possibility of using VA's laboratory. It felt this attempt would be a test on which future sharing between Navy and VA could be based.

After several negotiation sessions between local Navy and VA officials, the Navy proposed the following guidelines for using VA's Laboratory.

--All Navy patients (active duty and retired military and their dependents, both men and women), except children, would be eligible.

--Navy would pay for disposable equipment used during catheterization procedures on Navy patients.

--Navy would provide staff cardiologist supervision for procedures performed by VA. The procedures would be performed by VA cardiology residents in training.

--The Navy's payment would pay for disposable equipment and its provision of Navy staff cardiologist supervision would constitute payment to VA, with no direct transfer of funds.

Navy felt that sharing this service offered advantages to both parties. Shifting about 200 Navy patients a year to VA would ease the demands on Navy's overburdened laboratory. VA would benefit by increased workload, which would (1) enhance the resident training program, and (2) further justify the laboratory's existence.

Problems developed, however, when San Diego VA began trying to figure out exactly how to set up a sharing agreement. Since VA knew that some type of charge would be necessary to gain VA Central Office approval of the agreement, it finally agreed to furnish the supplies and charge Navy VA's interagency rate ($102 per inpatient day during fiscal year 1976). This rate was the primary cause of two major obstacles encountered by VA and Navy in their efforts to share. These obstacles were:

1. Lack of incentive to share. San Diego VA felt that it had no incentive to share facilities and equipment with Navy (or any other Federal facilities) since the catheterization payments ($102 a day for 2 days, or $204) would not cover the costs of supplies and personnel necessary to support Navy catheterizations. Further, at one time Navy wanted VA to consider Navy patients as its own and receive a funding increase through the appropriations process because of a higher workload, rather than be reimbursed by Navy. San Diego VA felt that the interagency reimbursement received from the Navy would at least cover some costs, if the funds collected were returned to San Diego VA. The reimbursement process was not clearly understood and led to the following closely related obstacle.

2. No local reimbursement. As San Diego VA understood the reimbursement process, the Navy reimbursements at interagency rates would flow to VA's Central Office and be credited to an appropriation account. It was unclear whether the funds would then be returned to the local VA hospital. The San Diego VA Hospital Director tried to obtain clarification on the reimbursement mechanism from VA's Central Office. He was told it "didn't know" whether the Navy funds could be returned to San Diego VA or would be kept in the VA general appropriation account. One San Diego VA official commented that VA's Central Office might prefer to keep the reimbursements to assure that "double dipping" did not

occur; that is, a service or facility already supported by appropriated funds would not be supplemented by reimbursement from another Federal agency. San Diego VA officials contended, however, that the appropriations for the cardiac catheterization laboratory would not be nearly adequate to cover expenses incurred by an influx of Navy patients. Consequently the officials believed they would have to be reimbursed locally or they would not routinely share their capabilities.

Over a period of several months, San Diego VA tried different agreements and authorities to develop a mutually acceptable sharing arrangement. For example, VA's Central Office approved an interagency agreement, under the Economy Act (31 U.S.C. 686), but told San Diego VA there was no known way Navy funds received for services could be reimbursed to the providing hospital. However, VA's Central Office advised that funds could be reimbursed to the providing hospital if VA had an approved sharing agreement under 38 U.S.C. 5053, the sharing law. With this in mind, San Diego VA drafted a sharing agreement in place of the interagency agreement and presented it to Navy. VA's price increased to $300 for each catheterization to recover estimated full costs.

Navy, meanwhile, had used VA's cardiac catheterization laboratory for 5 months under the interagency agreement, but stopped sending patients when the Naval Hospital Commander learned of the higher payments. Both Navy and VA officials felt the sharing had worked well, but Navy administrators thought that if they had to pay VA anything, they should pay only for supplies. They stated that the entire VA proposal would have to be renegotiated at an acceptable reduced price. A Navy physician told us, however, that Navy's cardiac catheterization laboratory's workload was reaching the saturation point and the same options as discussed on page 95 remained.

San Diego VA officials would be enthusiastic about continuing to catheterize Navy patients, but only if Navy agreed to a 38 U.S.C. 5053 sharing agreement. The officials told us that without this agreement, which did not seem likely, no further sharing would be attempted with Navy.

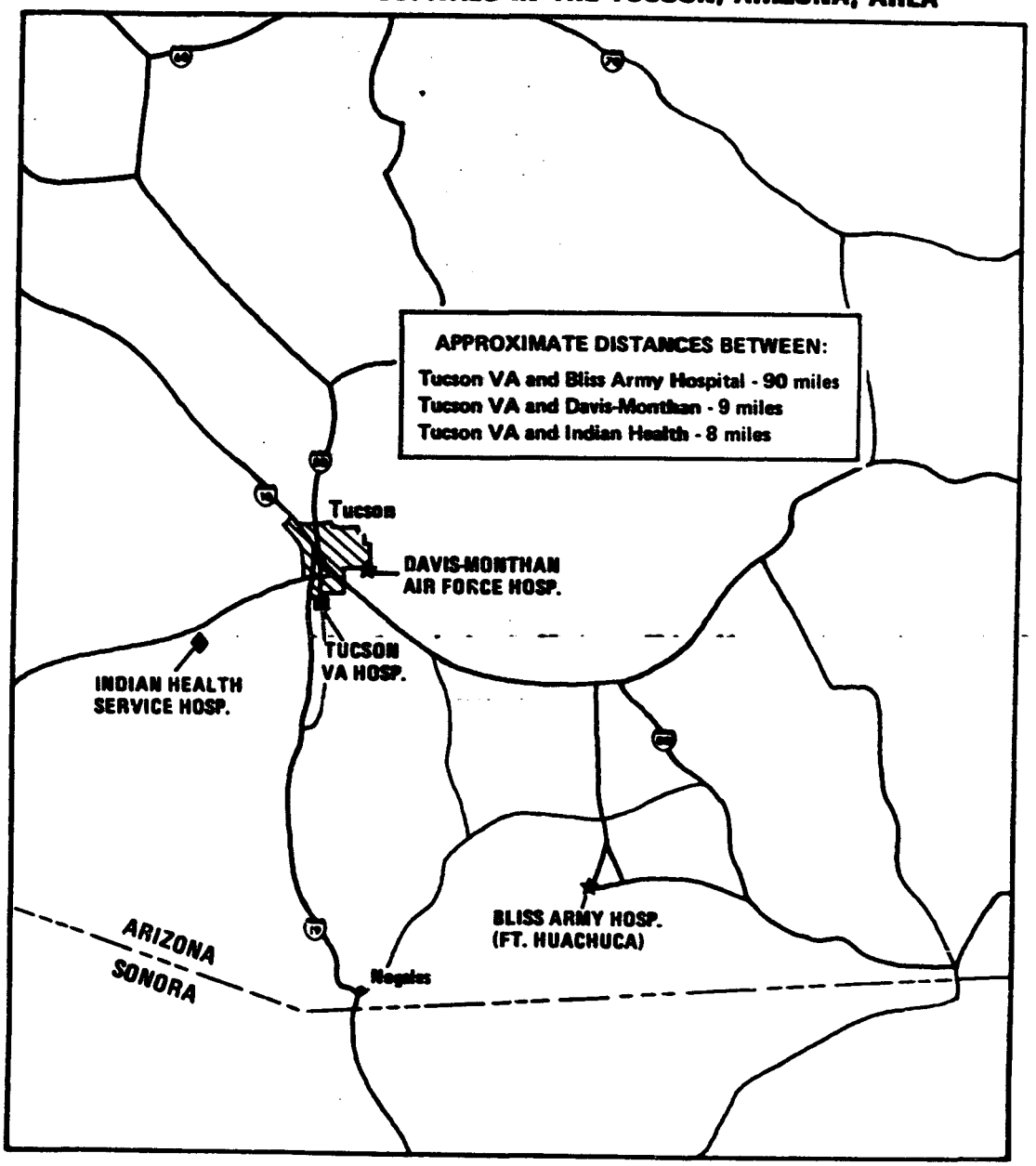
We were also told that several other services were being considered for sharing, including radiation therapy at the Naval Hospital and cardiac surgery at VA. We later found that San Diego VA had requested a radiation therapy unit at

a cost of about $895,000 for construction and equipment, so at least one other sharing opportunity has probably been lost.

VA officials identified other obstacles to sharing with Navy. They believed that VA's sharing law is complex and unclear. Under this law it is not clear which services are specialized and could be shared. Further, any agreement written in accordance with instructions is so complex that it is enough to discourage any potential sharers. Also, according to the San Diege VA Hospital Director, local hospital officials cannot approve sharing agreements; they must go to the Central Office, often a long process taking 60 or more days with many delays possible. He felt approval authority should rest with the hospital director, subject to Central Office review and veto if necessary. Early approval, he believed, would certainly expedite any sharing agreements local officials agree to be in the best interests of the Government.

APPENDIX IV

SELECTED FEDERAL HOSPITALS IN THE TUCSON, ARIZONA, AREA



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CASE STUDY 11

REIMBURSEMENT PROBLEMS CURTAIL SHARING BETWEEN VA AND OTHER FEDERAL FACILITIES

In fiscal year 1976 Tucson VA provided health services, including nuclear medical scans and electroencephalograms to military beneficiaries (active duty and retired members and their dependents), as follows:

--Davis-Monthan Air Force Hospital beneficiaries. Most services were performed on an outpatient basis, although a few individuals were treated on an emergency inpatient basis. During the year Tucson VA billed Davis-Monthan about $20,000 for services.

--Bliss Army Hospital beneficiaries. These patients were mostly military dependents, although some active duty and retired members were also treated. A VA hospital official told us no Army beneficiaries had been treated on an inpatient basis. Tucson VA billed Bliss about $6,000 for the services provided during fiscal year 1976.

If the military hospitals had contracted with local civilian hospitals for the services provided by VA, the costs would have been substantially greater than the $26,000 paid to VA.

In addition, Tucson VA provided a wide variety of both inpatient and outpatient services to Indian Health Service beneficiaries and billed the Indian Health Service about $126,000 for these services.

Tucson VA provided these services under the broad authority in the Economy Act (31 U.S.C. 685). This authority does not require formal sharing agreements between Federal agencies. Under this authority interagency reimbursements are based upon the actual cost of services. (However, VA's annual appropriations acts require reimbursement at rates established by VA to reflect the average actual costs of services provided to other agencies. These rates are approved by the Office of Management and Budget.)

Reimbursement difficulties

Until October 1976 Tucson VA received reimbursement from VA's Central Office for the services provided to the Air

Force, Army, and Indian Health Service. Tucson VA billed the other agencies at its interagency rates ($102 per inpatient day and $33 for an outpatient visit during fiscal year 1976). Tucson VA was depositing the payments in a VA Central Office receivable account. Then, during each fiscal year quarter, Tucson VA requested reimbursement from VA's Central Office for the amounts deposited. The requests were honored by VA's Central Office in the form of increased obligational authority to Tucson VA.

However, the reimbursement procedure was apparently not in accordance with VA Central Office's internal policy. Central Office officials said VA policy requires depositing reimbursements in a Central Office-controlled Treasury account with no increased obligational authority being granted to the providing VA hospital.

Nevertheless, Tucson VA received about $152,000 of increased obligational authority in fiscal year 1976 because the Central Office Budget Staff believed that the services to the other agencies had been rendered under formal sharing agreements authorized by VA's sharing law (38 U.S.C. 5053) instead of the interagency arrangements authorized by 31 U.S.C. 686. Formal sharing agreements must involve specialized medical resources, and reimbursement must cover full costs. Also, to encourage sharing, reimbursements revert to the providing VA hospital.

During the fall of 1976, the Central Office Budget Staff reviewed Tucson VA's quarterly report which requested reimbursement for the services rendered and discovered the discrepancies in the legal authority under which Tucson VA was providing services to other Federal beneficiaries. Consequently, Tucson VA's Fiscal Service officials were informed that, effective October 1, 1976, no more reimbursements to the hospital would be allowed for services to Air Force and Army beneficiaries. However, reimbursements were to continue for the services to Indian Health Service beneficiaries. No explanation was provided to local hospital officials for the inconsistency.

We were told in March 1977 that Tucson VA would continue to provide services to the Air Force and Army--even though reimbursements from VA's Central Office to the hospital for these services had stopped--at least until April 1977 when Tucson VA's budget was to be reviewed. However, we were informed in May 1977 that Tucson VA would no

longer provide services to the military beneficiaries because of increased workload and budgetary considerations.

The Central Office Budget Staff Director believes that it is incorrect to consider other agencies' reimbursements to VA hospitals as not reverting to the local hospitals. The Director told us that the total reimbursements received are used to offset the total budgetary requests made by VA to the Congress for medical care. Consequently, the total reimbursements from all sources--estimated in fiscal year 1977 for budget purposes to be $33 million--are redistributed to all VA hospitals. However, the VA budget system does not provide the means to determine how much reimbursement goes to each individual hospital.

Also the Director said the reimbursements for services to Indian beneficiaries had been and would continue to revert to Tucson VA. This action was considered necessary because of the hardship nonreimbursement would cause if Tucson VA could not count on having these substantial revenues to offset expenses of providing services to the Indians.

Although services to military beneficiaries by Tucson VA amounted to only about $26,000 during fiscal year 1976, Tuscon VA feels this is still worthy of consideration for full reimbursement to Tuscon VA. They believe that, at a minimum, some sort of reimbursement should be received. Services could be provided using VA's interagency rates if Tucson VA received the funds back.

However, Tucson VA would rather be paid full costs similar to those received under their formal sharing agreement with the Arizona Medical Center University Hospital. Under that agreement Tucson provided about $340,000 worth of services to the medical center in fiscal year 1976. Any full cost provision--a requirement for a formal sharing agreement--with the military is considered unlikely, however, since the military usually wants to pay only the interagency rates.

Additional obstacles impede successful sharing

Tucson VA has tried unsuccessfully several times to enter into formal sharing agreements through which medical services could be provided to military beneficiaries. In the latest of these attempts, Tucson VA officials met with Davis-Monthan Air Force Hospital representatives in May 1974 and proposed a sharing agreement to formalize, under 38 U.S.C. 5053, VA's sharing of specialized medical

services with Davis-Monthan. Under the proposed agreement, VA's charges were to be established using full costs of the specialized services, instead of the OMB-approved interagency rates. Davis-Monthan never formally responded to the proposal, but verbally told VA it could not pay anything but the interagency rates. In view of Air Force's refusal to pay full costs under a sharing agreement, Tucson VA resorted to the Economy Act's authority and provided services to Air Force at the interagency rates.

Tucson VA felt that Air Force--and other Federal--beneficiaries could be served without any reduction of service to eligible veterans. It also believed that for some specialized services--particularly nuclear medicine--all the staff and equipment needed to treat veterans were available. Furthermore, with no increases in staff or equipment, the Air Force beneficiaries could be treated at a benefit to both Air Force and VA. The Air Force patients would receive excellent services within the Federal community, and VA would be benefited by increased use of its resources. Also, and perhaps most importantly, professional people from Tucson VA and Davis-Monthan would be working together to provide better care for both veterans and other Federal beneficiaries.

The sharing efforts of Tucson area Federal officials represent an important step toward increased sharing of Federal medical capability. However, these efforts also illustrate the numerous obstacles which must be overcome before widespread sharing will occur.

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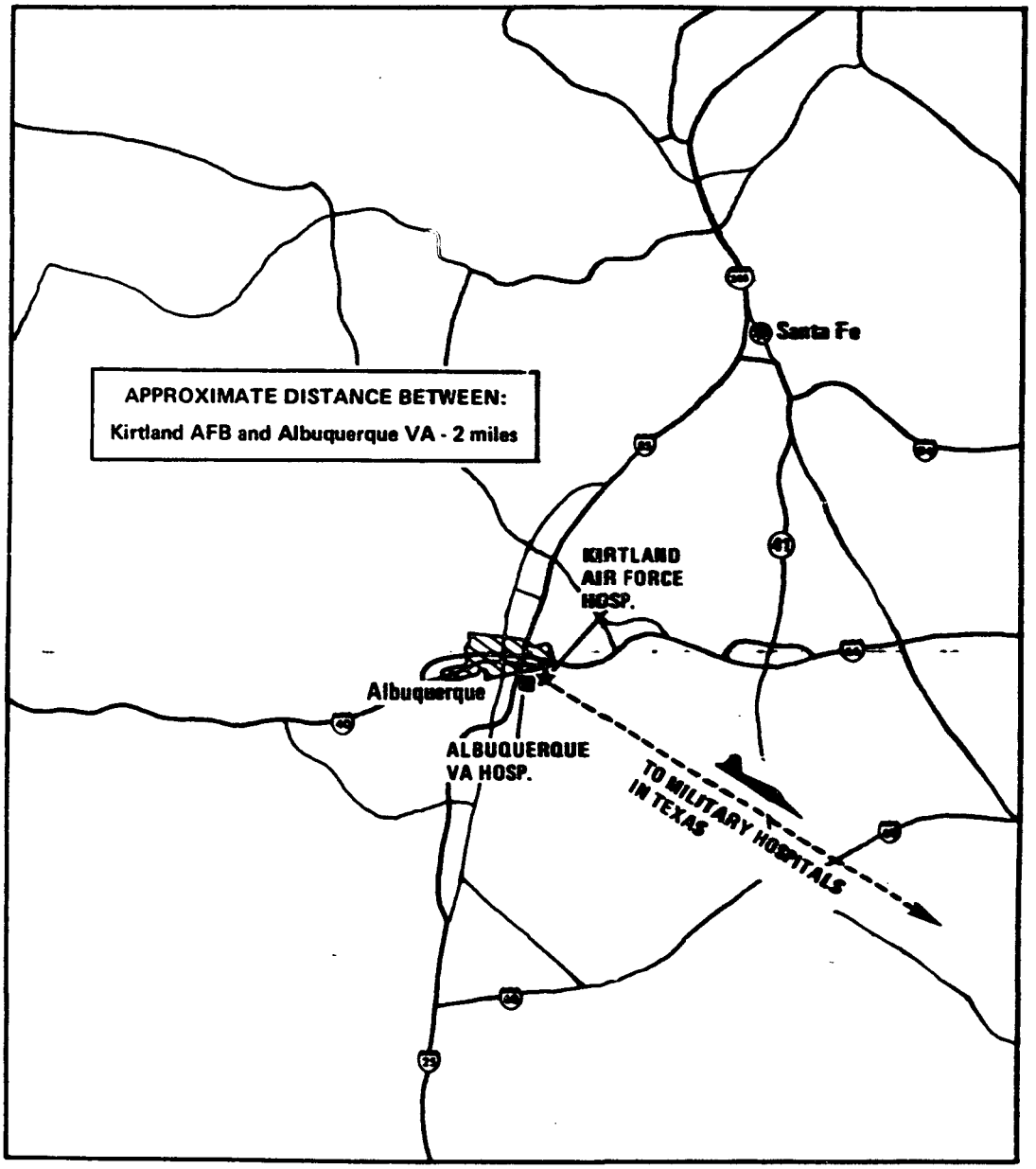
SELECTED FEDERAL HOSPITALS IN THE ALBUQUERQUE, NEW MEXICO, AREA



CASE STUDY 12

REGULATIONS LIMIT INCREASED USE OF WORKABLE VA/AIR FORCE SHARING AGREEMENT

Before mid-1975 Albuquerque VA performed, under informal arrangements, some laboratory tests for Kirtland Air Force Hospital at no cost. Albuquerque VA, however, felt that all arrangements should be formalized and asked VA's Central Office about the legality of informal agreements. VA's General Counsel responded that he knew of no authority for a VA/Air Force informal agreement. Any exchange of services, he stated, should be handled under either a formal sharing agreement or an interagency agreement. VA's Central Office subsequently advised Albuquerque to use an interagency agreement under 31 U.S.C. 686 if sharing were to continue.

Albuquerque VA thought a formal sharing agreement under VA's sharing law (38 U.S.C. 5053) would be more appropriate because the local hospital could be reimbursed. Consequently, VA and the Air Force approved a sharing agreement in March 1976; VA was to provide not only laboratory tests, but some internal medicine procedures as well. Kirtland was to receive a $14 credit of a $15 charge for every laboratory slide VA retained for teaching purposes.

Kirtland entered into VA's sharing agreement under authority of Air Force Regulation 168-10, which allows Air Force hospitals to pay community--or VA as interpreted by Kirtland--hospitals for supplemental services. Supplemental services are necessary medical procedures or tests beyond Air Force capabilities. Services may be purchased from the community, but the Air Force retains management of the patient. Kirtland officials stated that supplemental services may be obtained from hospital funds without command approval, so VA was an acceptable source.

Kirtland sent the proposed sharing agreement to its major command--Air Force Systems Command--for review. No negative comments were received, and Kirtland officials told us that the Air Force Systems Command Judge Advocate had verbally approved the agreement. With no unfavorable comments from the Command, Kirtland entered into the VA agreement.

According to VA and Air Force officials, the agreement worked well for over a year and was to be expanded. VA did not limit the categories of Air Force patients covered.

Active duty military, retired military, and dependents were all treated. Funds collected from Kirtland--about $8,400--were forwarded to VA's Central Office and later returned to Albuquerque VA as increased obligational authority, creating an incentive to share with Air Force. Both the Air Force and VA were pleased with the agreement and believed the potential for further sharing was excellent, subject to Air Force and CHAMPUS payment procedure limitations.

Kirtland officials believed, however, that Air Force is severely limited in dealing with VA for direct patient care. Direct care involves transfers or referrals; Air Force releases management of the patient to the accepting hospital. According to the officials, the following procedures apply:

--Air Force payments to VA for direct care, both inpatient and outpatient, are limited to interagency reimbursement rates. VA, of course, wants full costs under its sharing authority.

--For direct care, VA bills Air Force centrally. Kirtland is billed only when supplemental care is paid for by Albuquerque VA.

--Central billing is done for active duty military only. Retired military and dependents are usually referred under CHAMPUS, and community providers are paid by CHAMPUS.

--Kirtland's authority to enter into a VA sharing agreement for direct care is unclear since providers are reimbursed by Air Force headquarters or through CHAMPUS.

Kirtland officials stated that if more services could be shared with VA, the need for using the aeromedical evacuation system and CHAMPUS would be reduced, benefiting the patients and reducing costs. Patients are sent to other military hospitals by aeromedical evacuation and referred to CHAMPUS because these alternatives do not affect Kirtland's budget. Dependents usually choose CHAMPUS over aeromedical evacuation because of family ties and a desire to remain close to home. Active duty patients use either aeromedical evacuation or commercial flights to referral military hospitals in Texas. Also, if VA could be used more for active duty patients, they could remain on or near the base for treatment and Kirtland medical officials would know test results faster.

Kirtland officials feel that regulations must be revised to allow VA to provide direct care to Air Force patients,

including dependents. Also provisions would have to be made for Kirtland to pay locally the charges which are now being paid at headquarters for active duty and through CHAMPUS for retirees and dependents.

Kirtland officials said several additional services could be shared. Highlighted below are the services, where Kirtland obtains them now, and comments on VA's capabilities to share.

1. Hemodialysis. Retired military use VA if eligible as veterans; dependents use CHAMPUS. VA provides these services to a local non-Federal hospital under a formal VA sharing agreement.

2. Cardiac catheterization. Patients are sent either to other military hospitals in Texas or are treated under CHAMPUS. Kirtland may not use VA for direct inpatient admission, which catheterization requires. A VA official stated that Albuquerque has a new cardiac catheterization laboratory and would like to receive more patients.

3. Speech evaluation and therapy. Active duty patients are referred to Texas military hospitals; retirees and dependents are treated under CHAMPUS. VA also provides this service to a local non-Federal hospital under an approved sharing agreement.

4. Nuclear medicine. Service is obtained at a local non-Federal hospital. Payment is made from Kirtland's supplemental funds. Kirtland officials feel nuclear medicine services could be shared if VA's prices were lower than the local hospital's.

The Albuquerque VA Hospital Director told us that if VA has a service or facility needed by another Federal agency, then arrangements to accommodate the agency should be allowed and encouraged. VA's sharing is limited because the law (38 U.S.C. 5053) specifies that only unused capacity can be shared. The Director believed that reasonable increases in staff, equipment, or space should be allowed to use the Federal in-house capability more efficiently, thus benefiting the Government and all Federal beneficiaries. Moreover, he stated that the Albuquerque VA staff was becoming aware that work could be done for Kirtland to benefit VA and the Air Force. In addition, Albuquerque VA management will try to provide an incentive to the medical service chiefs and their personnel. This will be done by looking favorably on requests for staff to be paid for from sharing agreement

proceeds, if the workload dictates. Usually service chiefs and their personnel are reluctant to perform additional services for other agencies' beneficiaries, but if an incentive can be provided, more sharing would occur. The Director thought these steps would benefit VA and other Federal patients through increased efficiency and more work, leading to higher professional competence.

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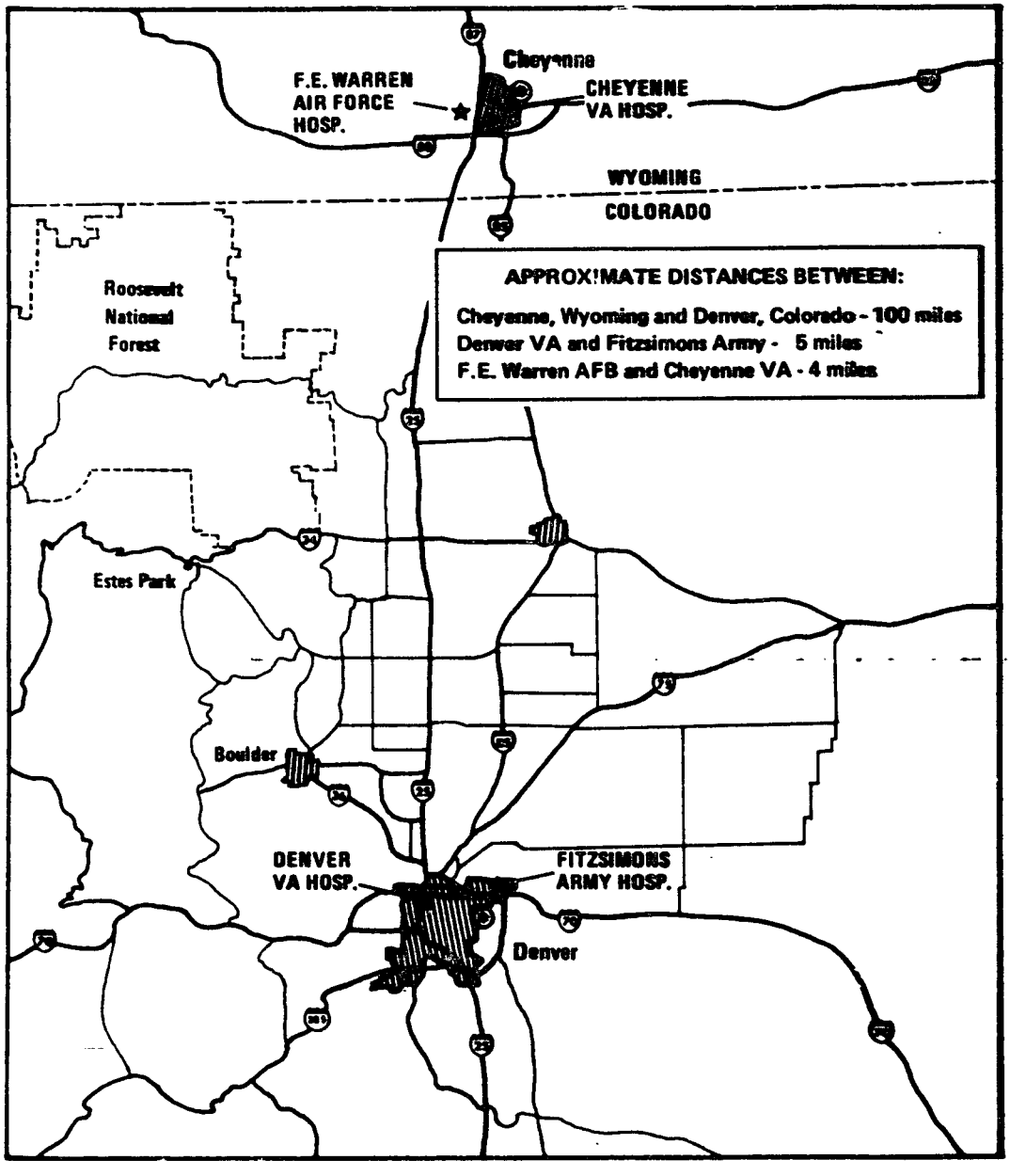
SELECTED FEDERAL HOSPITALS IN THE COLORADO – WYOMING, AREA



CASE STUDY 13

ADMINISTRATIVE INACTION AND ATTITUDINAL BARRIERS HAMPER SHARING BETWEEN VA AND AIR FORCE

In late 1973 F.E. Warren Air Force Hospital asked Cheyenne VA to allow it to use VA's radiology equipment for angiographic procedures on Air Force patients using Air Force staff and supplies. Warren's parent command, the Strategic Air Command, gave permission for such an arrangement.

In a letter dated November 23, 1973, Cheyenne VA sought VA Central Office approval for the arrangement without entering into a formal sharing agreement. The letter, signed by the Cheyenne VA Hospital Director, stated:

> "It seems logical that two Federal agencies should be able to work together in the spirit of cooperation and yet, I am aware that there may be some legal implications before we proceed further."

VA's Central Office notified Cheyenne that an exchange of service agreement would have to be completed and approved by the Central Office before the sharing could take place. Subsequently, an agreement to provide the service at no charge was prepared, signed by the Warren Hospital Commander and forwarded to the Central Office on January 28, 1974.

Although Cheyenne VA officials said they had made several inquiries about the status of the request, VA's Central Office took no action on the request. Cheyenne VA files show that in a telephone conversation between VA's Central Office and the Cheyenne VA Hospital Director on October 2, 1974, about a year after the initial request, it was agreed that the proposed contract was to be dropped for the time being. Cheyenne VA officials said by late 1974 the Warren radiologist making the request had left Warren and there was no longer any push from Warren to act. They said they were unaware of why VA's Central Office had not acted on the request.

Other than this attempt at official sharing, no further sharing had taken place between Warren and Cheyenne VA except for dental X-ray services. Cheyenne VA had provided dental X-ray service to Warren patients several times during the last few years. The X-ray, a large size not available at Warren, was provided on an informal, nonreimbursable basis. Warren and VA dental personnel arranged for the

X-rays. Cheyenne VA dental personnel asked other VA officials about the propriety of providing the service and were told that they should not provide the service unless Warren paid an outpatient fee of $39 for each visit.

Warren refers patients needing care beyond its capabilities as follows: (1) aeromedical evacuation to distant military medical facilities, (2) transportation to local hospitals, clinics, and physicians, and (3) transportation to Fitzsimons Army Medical Center in Denver--about 100 miles away.

According to Cheyenne VA medical personnel, some support could be provided Warren in orthopedic care, pulmonary medicine, gastroenterology, physical therapy, and surgical and dental consultations. VA personnel told us that in some cases, only limited support could be offered. However, these services could serve as initial opportunities for sharing between the facilities. This would be contingent, however, on eliminating some regulatory, budgetary reimbursement, and attitudinal factors which, according to Cheyenne and Warren officials, have impeded effective sharing between the facilities.

Legal and regulatory

According to Warren's Commander, Air Force regulations do not authorize providing routine medical care to many veterans eligible for care in VA hospitals. The Commander believed the regulations should be revised to allow Air Force hospitals to treat all veteran patients. Further, he said the absence of necessary guidance on sharing, particularly on sharing medical specialists, has served as a barrier to effective sharing with VA. The Commander believed sharing between DOD and VA can be improved by informing both parties of the benefits of sharing and by revising VA and DOD regulations to optimize sharing activities. Cheyenne VA officials related similar regulatory barriers. According to the Director, Cheyenne VA, regulations do not allow VA to provide routine medical services to uniformed services dependents. The Director said regulations governing sharing agreements stipulate that a VA hospital can enter into an agreement only when "excess capacity" exists within the hospital, i.e., when it has underused staff, space, or equipment. He explained it is sometimes difficult to properly define "excess capacity."

The Director, Cheyenne VA, was unsure whether Cheyenne VA could legally enter into formal sharing agreements (38 U.S.C. 5053) with other Federal agencies or whether such

an agreement was necessary for Cheyenne VA to provide care to Warren personnel. The Director believes a change in VA's mission is required which would allow VA hospitals to provide an increased level of care to active duty and retired service personnel and their dependents. Also current legislation governing the provision of medical care to dependents of service members by VA hospitals would require modification allowing VA hospitals to care for such patients.

Budgetary

Funding also hampers sharing. According to Cheyenne VA officials, Cheyenne VA was funded to provide 12,750 outpatients visits during fiscal year 1977. Recent Cheyenne VA projections indicate Cheyenne VA expects to receive requests for about 16,000 outpatient visits during the same period. In response to the rising demand for outpatient care, VA's Central Office established, by directive, priorities governing treatment provided outpatients. Under the directive beneficiaries from other Federal agencies, active or retired military personnel, and persons treated under sharing agreements are assigned the lowest priority for outpatient services. The Director said the funded level of 12,750 outpatient visits will permit Cheyenne VA to treat only higher priority patients, and since Warren's patients would fall into the lowest priority, Cheyenne VA could not provide care to these patients.

Reimbursement rates

Cheyenne VA's charge for outpatient service hampers sharing in a manner similar to that in which funding hampers sharing. Warren administrative personnel said that on several occasions they had contacted Cheyenne VA regarding the possibility of providing Warren patients with outpatient services. When the care required was available from Cheyenne VA, the charge exceeded the cost of obtaining the same care from Cheyenne community providers.

A case involving physical therapy required by an active duty Air Force member illustrates the problem. Warren contacted Cheyenne VA regarding the availability of certain physical therapy treatments and were advised that Cheyenne VA could provide the treatment at the rate of $39 for each outpatient visit. Warren also contacted two local community hospitals about the availability of the treatments and were advised that each hospital could provide the treatments. The charges at the community hospitals totaled about $4 for each visit after an initial one-time phsycian's referral charge of $10 to $15.

Warren expressed the belief that Cheyenne VA and Warren should share resources in a cooperative manner. However, because Cheyenne VA charges often exceed those for care at community resources, Warren has elected to use the community facilities.

Attitudes

Attitudes of Warren and Cheyenne VA officials may hinder sharing between the two facilities. For example, the Warren Commander told us his predecessor had advised him that past attempts to initiate sharing agreements with Cheyenne VA had been unsuccessful and further efforts would meet with a similar result. He had not approached Cheyenne VA with any sharing proposals because of these unsuccessful efforts. He believed an increased willingness to cooperate is required on VA's part before sharing can occur.

The Director, Cheyenne VA, said the reason no formal sharing agreements exist between his facility and Warren is because of the limited cooperation between the two facilities in the past. Cooperation to date has been on a case-by-case basis. The topic of using sharing agreements never arose except in the one attempt to share radiology services, which failed.

Further, Cheyenne VA officials told us the reasons Warren had not been considered as a surgical alternative during a recent closing of Cheyenne VA surgical suites was because of uncertainty over Warren's surgical capability. The officials said Cheyenne VA's longstanding relationship with and reliance on the Denver VA Hospital also were strong factors in the decision to send their surgical patients to Denver rather than contacting Warren.

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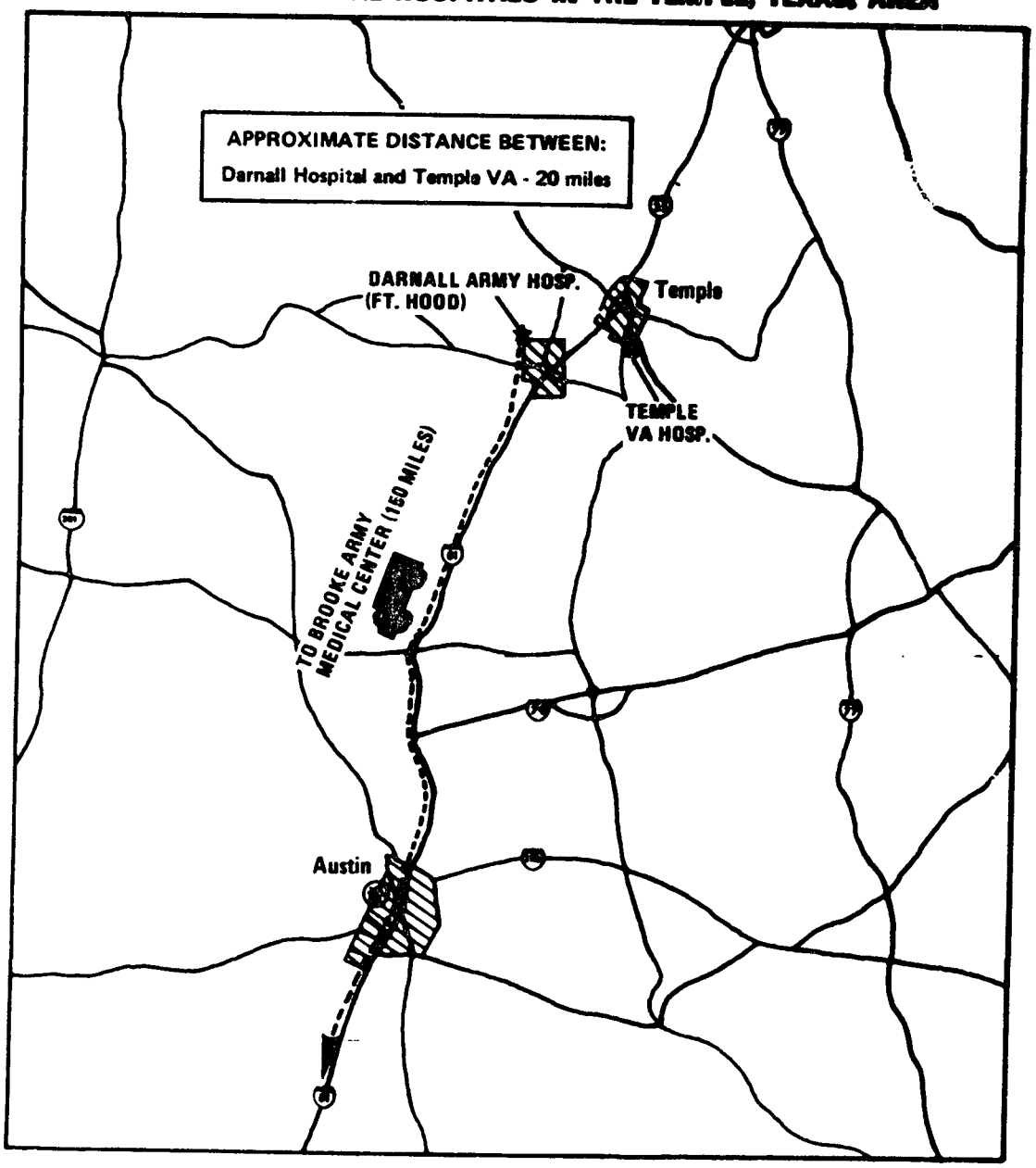
APPENDIX IV

SELECTED FEDERAL HOSPITALS IN THE TEMPLE, TEXAS, AREA



CASE STUDY 14

REIMBURSEMENT AND OTHER PROBLEMS PRECLUDE SHARING BETWEEN VA AND ARMY

Both VA and Army officials in the Temple, Texas, area agree that until reimbursement and other problems are solved, effective medical resource sharing between agencies will not occur. The Temple VA Hospital wanted a formal sharing agreement under 38 U.S.C. 5053 so it would be reimbursed for services to Army. Army was apparently reluctant to enter into a VA sharing agreement and had questions about whether regulations would allow active participation with VA. As a result, preliminary sharing attempts were frustrated and future possibilities appear unlikely.

Temple VA had performed some emergency treatments for Darnall Army Hospital (Ft. Hood) at interagency reimbursements rates, but refused to provide routine care without a formal sharing agreement. Consequently, when Darnall approached VA and requested a speech pathology (stuttering therapy) program for several military personnel, VA proposed a sharing agreement under 38 U.S.C. 5053, VA's sharing law. According to Temple VA officials, VA policy under sharing agreements (38 U.S.C. 5053) allows hospitals to be reimbursed, thus establishing an incentive for sharing. Funds collected under interagency agreements (31 U.S.C. 686), however, are not reimbursed to the hospital, creating a direct disincentive to sharing.

A VA official told us that the proposed sharing agreement had been explained to Darnall personnel and that the Army representatives were very surprised at the proposal and indicated:

--They had no authority to enter into a VA "sharing law" agreement.

--Army already had an interagency agreement with VA at standard inpatient and outpatient rates and wanted to hold VA to this type of agreement because funds were transferred at Army headquarters and Darnall would not have to pay out of the budget.

--The whole matter would have to be discussed with headquarters before anything could be done.

Despite VA attempts to follow up with Army, no word was received for about a year after the proposal had first

been discussed. VA officials told us they had practically forgotten the sharing effort, but could not understand why Army would not accept their offer. Even the cost would have been lower under the sharing agreement than interagency rates. A speech pathology visit would have lasted for 1 hour at $25; interagency rates were $33 for an outpatient visit ($39 during fiscal year 1977).

We could not confirm Army's original problems with VA's proposal, because the personnel involved had been transferred. However, another Darnall official believed the following difficulties would inhibit any future VA/Army sharing:

--The biggest stumbling block concerns reimbursement. VA wants a sharing agreement to perform services for Darnall, the costs of which are supposed to be full, including amortization of equipment. Army believes it should not have to pay VA's full costs and, in fact, believes that if VA has the capability, the services should be performed for nothing. Since reimbursement is required between Army and VA, however, questions arise about how much Army could pay VA. An Army hospital commander may supplement his hospital's capability as he feels necessary, according to Army Regulation 40-3. This applies to supplemental services only, where Army maintains management of the patient but refers the patient to a community facility for, for example, some specialized service beyond the hospital's capabilities. The regulations are unclear, though, about instances such as VA's proposal to charge the Army $25 an hour/visit for supplemental speech therapy. Army's Health Services Command told Darnall that VA could be paid the $25 but that Darnall officials should attempt to hold the cost down to $20, the standard outpatient charge for Federal beneficiaries other than military (e.g., a VA beneficiary) treated in Army hospitals. Overall, it is really not clear whether Darnall could pay VA anything more than the DOD interagency rates, so it is questionable whether the $25 VA asked would have been acceptable.

--A disincentive exists for Darnall to enter into a formal VA sharing agreement. VA's full costs for supplemental services under a sharing agreement have to come out of Darnall's own operating budget. If, however, VA would provide services at standard interagency rates and not require a sharing agreement, the Health Service Command would pay and Darnall's budget would not be affected.

--Also, it is questionable whether military dependents may be treated at a VA hospital. Although Darnall originally wanted to send only active duty patients to VA, dependents also need speech pathology services. According to Army Regulation 40-3, chapter 15, dependents are eligible for care at Public Health Service hospitals, but VA is not mentioned. Thus, the regulation may mean that even under a sharing agreement, dependents may not be treated in VA facilities.

Darnall officials also told us that until these problems are solved, it does not look promising for any Army/VA agreements. The need for speech pathology will still exist, as will the need for other services. VA has or will have, for example, angiography, electromyography, and nuclear medicine.

Darnall currently obtains these services in two ways: (1) active duty patients are sent by bus 150 miles each way to Brooke Army Medical Center (not a satisfactory arrangement for optimum patient care), and (2) patients covered by CHAMPUS usually obtain nonavailability statements and receive treatment from community sources. Darnall officials believed the patients and the Government would benefit if Temple VA could provide many of the needed services. Such an ideal arrangement does not seem likely though, because of the constraints--primarily reimbursement.

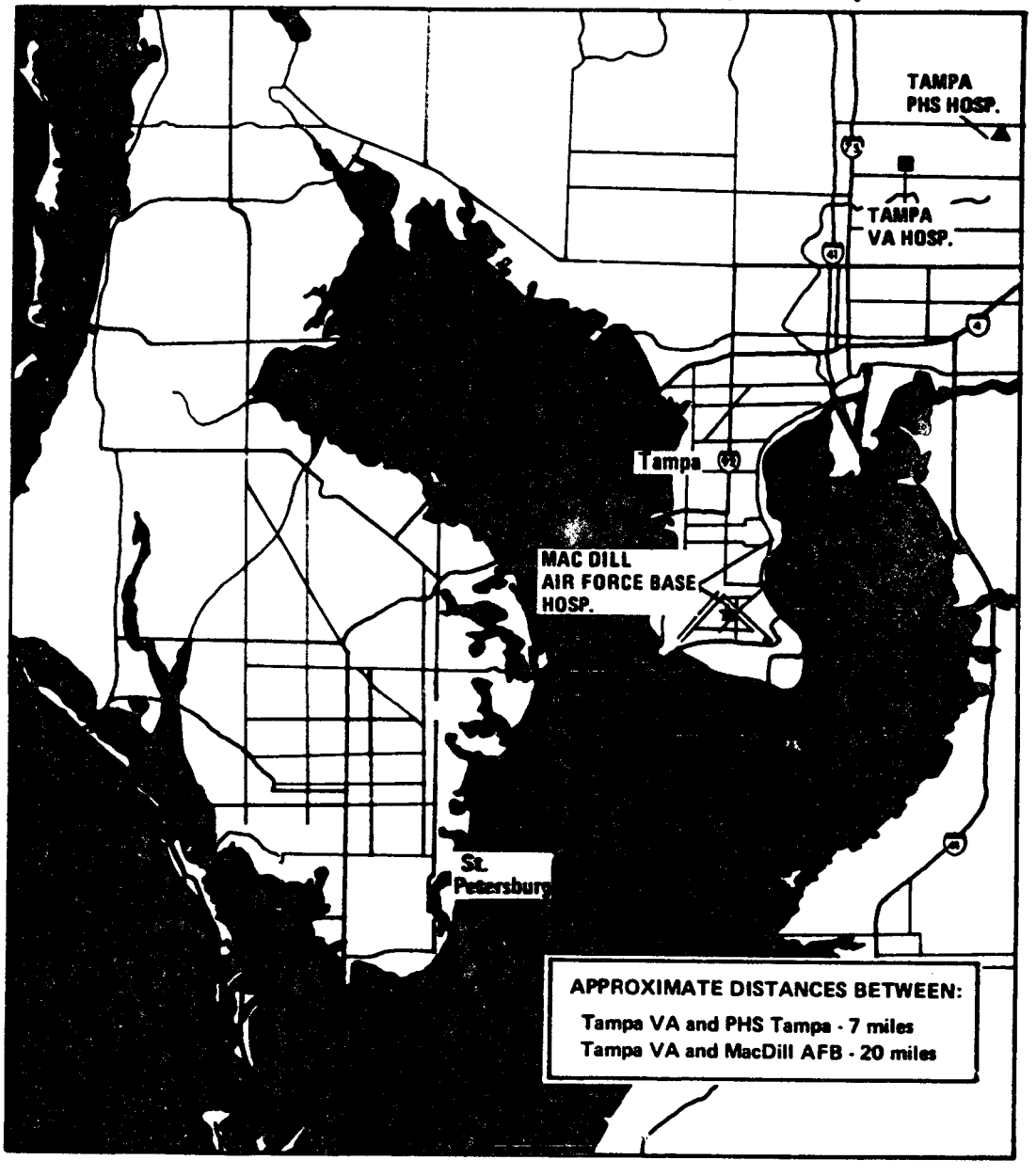
Temple VA highlighted other problems for us that they had encountered with Army's proposed sharing agreement and with sharing agreements in general.

1. VA's sharing law--38 U.S.C. 5053--is interpreted too restrictively by VA's General Counsel and therefore disallows sharing of some nonspecialized medical services which could easily be shared. The officials felt the law should allow sharing of all medical services, particularly between Federal agencies, when it is advantageous to the Government.

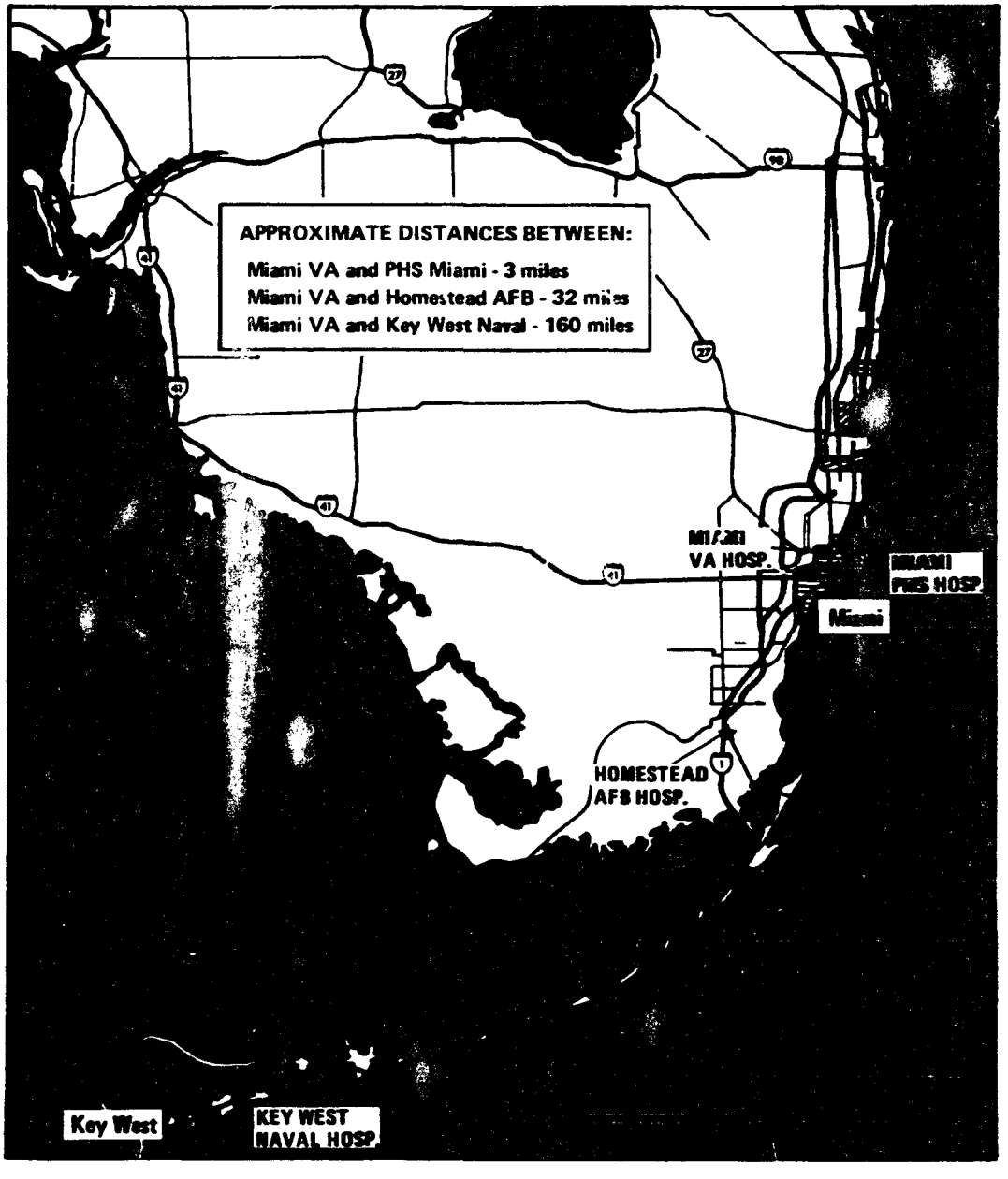
2. Definitive guidance does not exist for interagency agreements. This condition creates negotiating problems, which are compounded when dealing with Army personnel who are regularly rotated.

3. Adding staff or equipment to support services shared with other agencies is not allowed. Even if VA has a service needed by another agency, the sharing must be done on a excess capacity basis. VA's sharing law should allow for expansion, the officials believed.

SELECTED FEDERAL HOSPITALS IN THE TAMPA, FLORIDA, AREA



SELECTED FEDERAL HOSPITALS IN THE MIAMI - KEY WEST, FLORIDA, AREA



CASE STUDY 15

SHARING OPPORTUNITIES OVERLOOKED DUE TO INEFFECTIVE COORDINATION BETWEEN PHS AND VA

In the Miami and Tampa, Florida, areas, VA had the capability to share several medical resources with PHS. However, Miami PHS officials were unaware that VA regulations permitted all PHS beneficiaries to be treated in VA facilities and, consequently, did not refer any nonveterans for care. In the Tampa area, no PHS patients were referred to VA for care although meetings had been held between PHS and VA officials to discuss opportunities for sharing.

Miami area

The Miami PHS outpatient clinic is small, providing general medical and dental outpatient care. Special clinics are staffed by PHS contract physicians, and other services, such as psychiatry, neurology, and radiology are procured locally from private physicians. During 1976 PHS purchased about $38,000 in outpatient services. Inpatient care for PHS beneficiaries is provided by the New Orleans PHS Hospital, Homestead Air Force Hospital, and local Miami hospitals. PHS Miami spent about $190,000 at civilian hospitals for inpatient services during 1976.

In several cases a nearby VA hospital could have provided the types of services PHS purchased during 1976. Generally, PHS purchased a wide variety of services, and Miami VA Hospita officials stated that all PHS patients could have been served in the spinal cord injury, cardiology, neurology, and nuclear medicine services. Savings that could have resulted had PHS used VA services are shown below.

Community services purchased	Number of Inpatients	Instances Outpatient	Cost to PHS	Cost at VA	Savings to PHS at VA
Spinal cord injury	2	-	$49,073	$26,912	$22,161
Cardiology	1	-	15,422	3,132	12,290
Neurology	-	28	1,880	1,092	788
Nuclear medicine	-	5	666	195	471
			$67,041	$31,331	$35,710

Miami PHS officials said they were unaware that VA could provide services to all PHS beneficiaries and, consequently, had referred only PHS beneficiaries who had served in the military to VA. During 1976, PHS did refer two veterans to Miami VA. However, VA hospitals were not considered as an alternative source of treatment to other types of PHS beneficiaries. Instead other civilian hospitals or the New Orleans PHS Hospital were used.

Many PHS beneficiaries are referred to hospitals by PHS contract physicians--a network of approximately 300 private physicians under contract to PHS who provide care to PHS beneficiaries in areas where PHS facilities cannot be justified. Patients seen by contract physicians are eligible to receive the same benefits as persons seen in an organized PHS facility. However, they are customarily referred to hospitals with whom PHS contracts im the absense of a specific legislative mandate to seek care from other Federal sources when available.

According to VA directives, PHS beneficiaries could be provided hospitalization, outpatient treatment, and physical examinations if duly authorized. Authorization consists of verbal approval by PHS officials followed by a memorandum. Also PHS regulations allow outpatient clinics to refer patients to VA hospitals when the urgency of the condition does not permit treatment in a PHS hospital.

However, VA regulations appear inconsistent regarding treatment of PHS and DOD dependents. VA Manual M-1, part I, section IV, precludes DOD dependents from all but emergency VA treatment, while the same section authorizes VA to treat all PHS beneficiaries, which could include DOD dependents. Miami VA officials said they would verify with VA's Central Office what is included in the terms "Beneficiaries of the Public Health Service" from the manual. The officials believe that the Central Office did not intend for VA to treat all PHS beneficiaries (including dependents of DOD personnel) while [illegible]ing this same group treatment under a different secti[illegible] [illegible]f the manual.

The lack of effective coordination between these Federal facilities demonstrates that savings and fewer referrals to distant facilities could result from increased interagency sharing. At the time of our study, VA was planning to meet and arrange sharing procedures with PHS since apparently nothing in the regulations precluded sharing. Miami VA had planned to request clarification from VA's Central Office about the apparent inconsistent regulation noted above, however.

Tampa area

The Tampa PHS Outpatiemt Clinic provides general medical and dental services and purchases specialized services, such as radiology, dermatology, and orthopedics from local physicians. Inpatient care is provided by community sources, the New Orleans PHS Hospital, and MacDill Air Force Base Hospital. In 1976 PHS purchased over $12,000 in outpatient services and $224,000 in inpatient services from community providers.

During 1976 the PHS Clinic purchased 13 different types of services from community sources, including cardiology, ophthalmology, and psychiatry, both inpatient and outpatient. Tampa VA Chiefs of Psychiatry; Ear, Nose, and Throat; Ophthalmology; and Nuclear Medicine stated that their units could have provided services to PHS without an increase in personnel. The Tampa VA Hospital Director further stated that VA could have assumed all of PHS community-purchased workload except for neurology and orthopedic services. From a limited sample of 15 PHS psychiatric; ear, nose, and throat; and urology patients treated at community facilities, an estimated $14,000 could have been saved if VA had been used.

Since Tampa PHS spent about $236,000 during 1976 for services that VA could have provided, a potential for savings does exist.

However, according to PHS headquarters officials, a distinction should be recognized between PHS operating procedures and those of other Federal providers which may limit savings through sharing in certain geographical areas. PHS expenditures for care from non-Federal sources largely represent expenses incurred for care provided to eligible beneficiaries by contract physiciams. Contract physicians are generally located in geographical areas which have no Federal health care facilities. Therefore there is generally no other alternative source of treatment except the PHS contract physician.

The Tampa PHS Clinic Director was unaware that VA regulations permitted PHS bemeficiaries, who were not veterans, to be treated in VA facilities. Therefore, he stated that VA hospitals were not usually considered as an alternative to civilian hospitals or the New Orleans PHS Hospital because the majority of PHS beneficiaries were nonveterans and, he believed, ineligible for VA care. He also stated that in most instances, especially emergencies, patients go to hospitals before the clinic is notified.

(Currently this is normal PHS procedure for providing care to its beneficiaries on a nationwide basis.) However, he acknowledged that in some cases the patients' condition would allow referrals to VA. He said that before he could send a PHS beneficiary to Tampa VA, he would have to request approval from the New Orleans PHS Hospital.

CASE STUDY 16

SHARING LAW PRECLUDES VA FROM PROVIDING SERVICES TO AIR FORCE

In May 1977 representatives from the Tampa area Federal health care providers--Tampa VA, MacDill Air Force Hospital, the PHS Clinic, and the Coast Guard--met to discuss sharing medical services. This meeting was the first attempt to explore the possibility of local Federal medical facilities sharing services. Before the meeting there had been minimal contact between the area's Federal medical facilities. Tampa VA, for example, had provided only a limited amount of medical services to other Federal facilities, specifically some physical examinations and hospitalization for active duty military members pending disability retirement and becoming VA beneficiaries.

The possibility of MacDill obtaining radiology services from Tampa VA was discussed at the meeting. MacDill needed radiology services which would cost about $240,000 annually to purchase from private providers. VA estimated that it could meet MacDill's needs for an annual cost of $120,000--a savings to the Air Force of $120,000 a year.

In June 1977 Tampa VA sent a proposed sharing agreement to VA's Central Office requesting approval for VA to provide radiology services to MacDill. The proposal stated that:

> "* * * The radiology services of this hospital has had no difficulty in recruiting physicians in that specialty. We would have no difficulty over a period of time of adding to the professional staff. On the basis of this knowledge, we have reviewed MacDill's workloads and felt we could easily provide the services for $120,000 a year. This would give us adequate funds to recruit two radiologists and a clerk typist for transcription work. The MacDill Air Force Base would deliver the [X-ray] films to be read to the Veterans Administration Hospital."
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> * * * * *
>
> "This hospital is perfectly willing, in the spirit of Federal cooperation, to provide this service to the MacDill Hospital. It would be necessary that the hospital be allowed to accept these funds from MacDill, similar to the current

practice the VA employs in sharing agreements with other universities and hospitals. This money is obviously necessary for the cost of the personnel required * * *"

* * * * *

"This is an excellent opportunity for the hospital and the VA to demonstrate a willingness and ability to perform a service for another Federal agency. It is evident such arrangements would save tax dollars."

VA's sharing law prevented the agreements from being approved. VA's Central Office denied the request for several reasons. First, the proposal indicated it would be necessary to recruit two radiologists and a clerk typist to serve MacDill's need. The Central Office stated that VA has no authority under a sharing agreement to recruit personnel for serving nonveterans' needs. Second, VA's sharing law permits VA to share only specialized medical resources that are unique in the medical community or can be fully used through mutual use. Since Tampa VA stated that MacDill's needed services are available in the community, they could not be considered unique. Lastly, since Tampa VA was not able to meet MacDill's need with the present staff, the requirements for maximum use through mutual use could not be met.

CASE STUDY 17

REGULATIONS RESTRICT SHARING BETWEEN VA AND AIR FORCE

In the Tampa and Miami areas, several regulations restricted treatment of Air Force dependents in VA facilities and directed intraagency transfer of DOD patients or referral to CHAMPUS instead of using another Federal agency's capability.

During 1976 MacDill Air Force Hospital in Tampa obtained various health services through the aeromedical evacuation system, CHAMPUS, and contracts with local civilian sources. Nearby Tampa VA could have performed some of these services. Pathology and nuclear medicine laboratory tests were the two most predominant services obtained, accounting for about $40,000, or about one-fifth of MacDill's 1976 supplemental care budget. A MacDill official said that a few patient specimens had been sent to Tampa VA, but most had been sent to a private laboratory.

Tampa VA's Director said that VA would have welcomed MacDill's laboratory work. The Chiefs of Tampa VA's Laboratory and Nuclear Medicine Services said that all MacDill's laboratory testing procured from private laboratories could have easily been performed at Tampa VA except for a few specialized tests.

Two obstacles to sharing were identified concerning VA's performing laboratory tests for MacDill: (1) questions about costs and (2) reimbursement to the providing facility.

MacDill said it would be willing to share with VA if there were a cost savings. VA's Chief of Laboratory Services said that the testing could be done at a slightly lower cost and service would have been more responsive than in the private laboratories. On the other hand, the Chief of Nuclear Medicine said the cost in his section would have been slightly more than in private laboratories. But VA performs the tests in duplicate to increase reliability, and it provides consultation regarding diagnostic indications. Neither service is normally provided by the private laboratories. Thus, VA prices would apparently have been at least competitive.

However, the Tampa VA Hospital Director said the major obstacle to sharing laboratory services was that the hospital needed additional funds to pay for supplies used to perform MacDill's tests. He believed this could be accomplished by Tampa VA and MacDill entering into a formal sharing agreement under 38 U.S.C. 5053. Tampa VA would then charge for supplies used and retain the funds. MacDill officials, however, had just recently become aware that they could enter into an agreement with another Federal hospital. Consequently, at the time of our study no firm progress toward sharing laboratory services had been made.

A similar situation existed between the Miami VA Hospital and Homestead Air Force Hospital. Homestead acquired a wide variety of health services from outside sources in 1976 through the aeromedical evacuation system, CHAMPUS, and contracts with local civilian sources for supplemental care. Neurology and nuclear medicine were the two most predominant services obtained for which Miami VA had capability. During 1976, 51 neurology inpatients were air evacuated to other DOD hospitals and 100 nuclear medicine scans were procured from private sources using Homestead's supplemental funds.

All 51 neurology inpatients were given a routine air evacuation precedence, and most were classified as either walking or mobile. Only three were classified as immobile. In addition, eight patients were air evacuated to military hospitals in Georgia, Mississippi, and Texas for nuclear medicine scans. All were given routine precedence and classified as walking or mobile. This is a questionable use of the air evacuation system, particularly when excess Federal capability existed nearby.

Miami VA's Chief of Neurology and Chief of Nuclear Medicine believed their services could have handled all 51 neurology inpatients and could have performed 90 of the 100 scans. However, Homestead officials were unsure of their authority to enter into a formal sharing agreement and had made no attempt to negotiate one.

In addition Homestead and Miami VA identified administrative regulations as major obstacles to sharing. The overriding obstacle was an Air Force regulation requiring intra-agency transfer of patients. Secondary was VA's regulation which impedes DOD dependents from being treated in a VA facility.

Two military directives were cited by both Homestead and MacDill as obstacles to sharing. DOD Directive 5154.6, dated November 26, 1974, states that:

> "In order to provide for patient welfare and assure best use of hospital specialty services and bed availabilities, patients will be regulated--unless otherwise directed--to the nearest uniformed services medical treatment facility which is capable of providing the required care."

In addition, Air Force Regulation 168-10, dated July 22, 1974, establishes the following order of priority for obtaining medical services not available at an Air Force facility:

1. Another uniformed services medical facility.

2. A VA medical facility.

3. A civilian source.

Homestead and MacDill officials stated that they have obtained most of their supplemental care for active duty patients from the first priority listed by evacuating the patient to another DOD medical facility. While active duty patients are the primary recipients of this service, dependents and retired personnel may also be transferred. However, the officials stated that most dependents and retired personnel do not prefer to be transferred to another DOD facility because of the distance. They subsequently request that supplemental care be furnished locally. Because VA regulations impede the routine treatment of dependents at VA facilities, Homestead and MacDill have bypassed the second priority (VA medical facilities) and have purchased the needed services from civilian sources or through CHAMPUS. A major factor in the decision to use CHAMPUS is that the program is not paid for from the military hospital's budget. The same is true for the air evacuation system. If patients were transferred to VA, the hospital would be charged for services.

Homestead and MacDill officials told us that military dependents are a substantial portion of their workload. Because of a VA regulation restricting dependents from being treated in VA facilities, Homestead and MacDill have made few efforts to request medical services from VA.

CASE STUDY 18

LACK OF COORDINATION AND REGULATIONS PRECLUDE SHARING BETWEEN NAVY AND VA

While there is an apparent excess of some medical services at the Key West Naval Hospital, Florida, many veterans living in the area are traveling about 160 miles for treatment at the Miami VA Hospital. Area veterans are also being treated by community providers, when some could possibly be treated at the Naval Hospital. Navy and VA have not coordinated efforts in the area, and Navy identified two regulations which would preclude sharing with VA. VA would be interested in establishing cooperative arrangements with Navy. Such arrangements could benefit VA patients and more fully use existing Federal capabilities.

In recent years the Key West Naval Hospital has been experiencing a declining patient workload. It was originally built to accommodate 200 beds, but reductions have occurred in the last 3 fiscal years to 70, 48, and finally 39 beds. Navy officials said the reductions were due to a reduced mission since the Vietnam crisis concluded. In 1976 the inpatient occupancy rate averaged 81 percent--35 persons daily--and an average of 19 physicians were on board throughout the year. About 8,600 outpatient visits were recorded each month during 1976, an average monthly workload for each physician of 452. In comparison, each physician's average monthly outpatient workload at Homestead Air Force Hospital during the same period was 649.

For the first 6 months of 1977, Key West Naval Hospital's occupancy rate decreased from 20 patients in January to 13 patients daily in June. For this period the average occupancy rate was 48 percent, or 19 persons daily. Outpatient visits for the same period also decreased to a monthly average of almost 6,200. This amounts to an average monthly outpatient workload for physicians assigned during July 1977 of 388.

These statistics indicate that the Key West may have some excess inpatient and outpatient capacity, which VA beneficiaries could possibly use. VA has estimated that over 9,000 veterans live in Monroe County, where Key West is located. Miami VA records showed 35 Key West area veterans had been treated from May to August 1977. They live closer to the Key West Naval Hospital than the Miami VA. From Key West to Miami is a trip of about 160 miles on hazardous roads. From an analysis of the services these 35 veterans received

at Miami VA and the services available at Key West, we believe at least 12 could have been treated at the Naval Hospital. Ten were outpatients and 2 were inpatients. Conditions treated ranged from pneumonia (inpatient) to a hernia, an ear infection, and a swollen right knee (all outpatients). Treatment data were not available for 11 more patients who lived closer to the Naval Hospital than VA, but some of them could possibly also have been served by Navy.

In addition, a Bay Pines, Florida, VA official who maintains centralized data on outpatient services purchased from private physicians by veterans in VA Medical District No. 12 told us that 141 medical treatment information cards have been issued to veterans living in the city limits of Key West. These cards are issued to veterans who live a great distance from a VA facility and desire to obtain outpatient medical treatment for a recurring illness from local private physicians or another Federal medical facility. VA reimburses the Federal facilities their actual costs and pays the private physicians reasonable fees. The limit is $40 monthly unless the doctor submits a medical plan to VA for approval to exceed the limit. The official also said experience has shown that the 141 veterans have spent an average of $60 monthly each--about $8,500 monthly, or $102,000 annually. Consequently, VA is raising the limit to $60 a month. We believe that some of these 141 veterans could possibly be treated at the Key West facility if Navy would allow it.

According to the Bay Pines VA official, most VA cards have been issued in the Pensacola area of Florida. The nearest VA facilities are about 200 miles from Pensacola, so the U.S. Naval Hospital, Pensacola, and Eglin Air Force Base Hospital have been very cooperative and treated many card-carrying VA patients in the area. However, the Key West Naval Hospital had refused to see VA patients for about 3 years. The official said that the reasons offered by Key West for not serving veterans were (1) it had no mission to serve veterans and (2) it lacked sufficient staff to serve veterans.

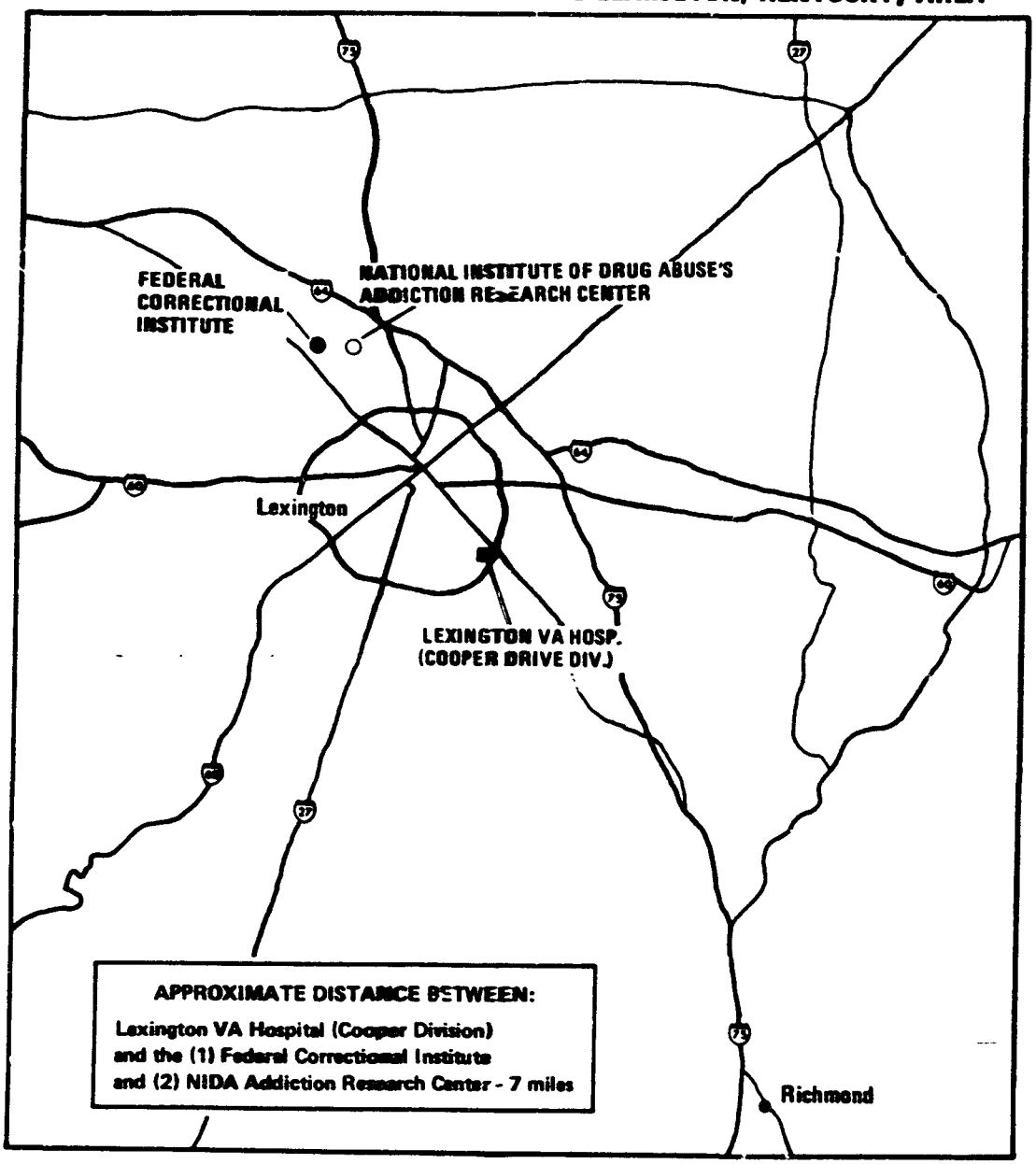
Further, Key West Naval Hospital's Commander told us that Navy's mission does not include providing service to veterans or any other Federal beneficiary. He said he would oppose the idea of providing service to anyone outside Navy's mission.

Several VA officials in Florida said a veterans organization was requesting VA to establish an outpatient clinic and a small inpatient facility in Key West. This would prevent

veterans living in the area from having to drive over 100 miles for treatment at Miami VA. The officials also said they were very interested in making an arrangement with the Key West Naval Hospital to share facilites rather than establish a new VA facility.

This appears to be am excellent opportunity for interagency sharing in the in the Key West area. Veterans living in the area could benefit substantially from reduced travel, Navy facilities could be more optimally used, and Government expenditures for health services by the private sector could be reduced. Possibilities include a sharing agreement with Navy for treating veterans within existing capacity or through supplementing Navy staff with VA personnel.

SELECTED FEDERAL HOSPITALS IN THE LEXINGTON, KENTUCKY, AREA



CASE STUDY 19

POTENTIAL TERMINATION OF VA SERVICES TO OTHER FEDERAL AGENCIES DUE TO CHANGE IN SHARING AUTHORITY

In fiscal year 1976 the Lexington, Kentucky, VA Hospital was the most active VA hospital in regard to the number of formal sharing agreements (38 U.S.C. 5053) with other Federal facilities. The Lexington VA Hospital had two of the six sharing agreements and accounted for about $78,000 of the $99,000 total services exchanged between VA and all other Federal agencies in fiscal year 1976. These agreements were with the Bureau of Prisons' Federal Correctional Institute and the National Institute of Drug Abuse's Addiction Research Center, both in Lexington.

Under each agreement, Lexington VA provided surgical intensive care service, open-heart surgery, and medical intensive care. All these services were highly specialized and consequently could be provided under VA's sharing law, which requires full cost reimbursement to the providing hospital. In September 1976 Lexington VA requested renewal of the agreements and forwarded the proposed formal sharing agreements to VA's Central Office for review and concurrence. In December 1976 the Central Office notified the Lexington VA Hospital Director that the agreements had been disapproved. The Central Office stated that it would be more appropriate to provide services under 31 U.S.C 686.

The net effect of this change was that (1) charges for services would be limited to VA's interagency rates, regardless of full cost, (2) Lexington VA would not be reimbursed, and (3) the parties could be Federal agencies only.

After considering these factors, the Director requested on January 24, 1977, that an exception be granted under 31 U.S.C. 686 to allow reimbursements to Lexington VA at rates equal to the costs of specialized medical services which were other than routine. The Director further explained that Lexington VA's resources which support ongoing programs for VA beneficiaries would be severely restricted if authority to obtain actual cost reimbursement was not received. Without such approval, he stated, VA's own local program needs would necessitate termination of the service relationships with the Federal Correctional Institute and the Addiction Research Center.

VA's Central Office notified Lexington VA in April 1977 that an exception would not be granted. A Lexington

APPENDIX IV

VA official told us that as a consequence, Lexington VA has not been able to recover the costs of these services. Services have not yet been terminated, but the budgetary impact may be such that Lexington VA will be unable to continue to provide them.

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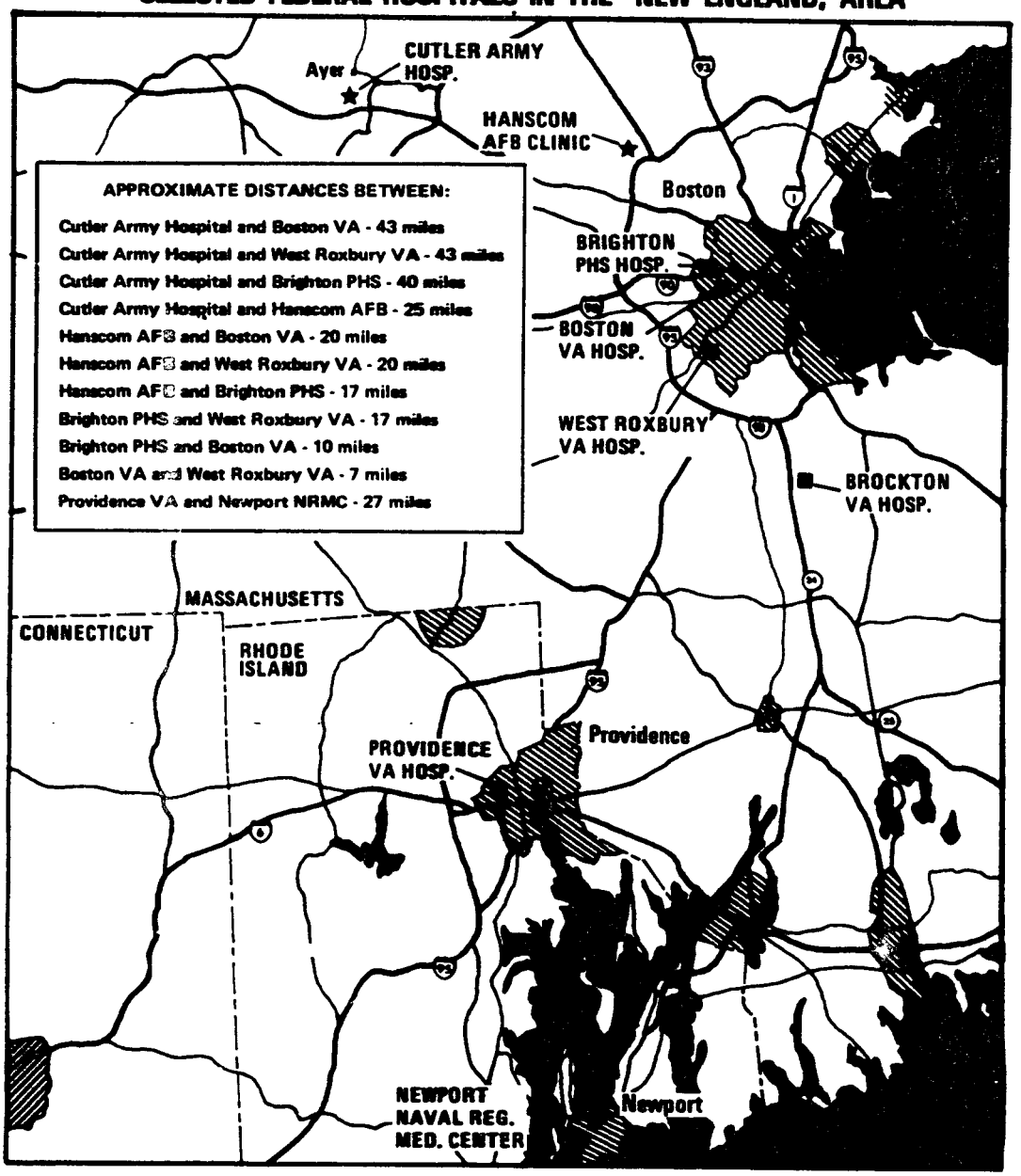
SELECTED FEDERAL HOSPITALS IN THE NEW ENGLAND, AREA



CASE STUDY 20

INTERAGENCY SHARING OCCURS IN NEW ENGLAND, BUT CERTAIN OBSTACLES STILL EXIST

DOD, VA, and PHS facilities in the greater Boston area are sharing some services, but questions about proper sharing authority, beneficiary eligibility, and reimbursement procedures hamper increased sharing. Current sharing is informal and occurs because of local initiative and cooperation. However, sharing in certain other Federal facilities in New England is rare.

Interagency sharing in the greater Boston area takes place between Cutler Army Hospital, the PHS Hospital, the Boston and West Roxbury VA Hospitals, and the Hanscom Air Force Base Clinic. The officials we spoke with generally agreed that current sharing is being done out of necessity. The DOD facilities and the PHS Hospital need many services available at the VA Hospitals, and the VA Hospitals have made their services available. In certain instances services have also been provided between non-VA facilities.

Boston and West Roxbury VA have the widest range of specialized services available of any of the Federal facilities in the greater Boston area. Consequently, they act as referral centers for other VA hospitals and provide some services to the PHS Hospital and DOD facilities in the area. As of May 31, 1977, they had provided other Federal agencies almost $243,000 in services during fiscal year 1977. These services involved a total of 141 inpatients and 247 outpatient visits.

Confusion about sharing agreements

Cutler's Commander said he isn't authorized to enter into formal sharing agreements. However, he did not think such agreements were needed or desirable. The Commander stated that the current informal arrangements are working very well. Using an informal arrangement the PHS Hospital accepts any patient Cutler refers, if the service is available, as do Boston and West Roxbury VA. The only exception is that the VA hospitals will not accept dependents. The Commander said VA regulations prohibit VA from accepting military dependents.

On the other hand, the PHS Hospital Director said:

--He would like to have formal agreements with the VA Hospitals.

--Although VA is not formally committed to providing the services, the VA hospitals have been very cooperative in accepting PHS patients, particularly for outpatient tests.

--A formal agreement with VA would give him some assurance that the services would continue to be available.

--The PHS hospital does not need formal agreements with the DOD facilities for which it provides services because they are all members of the uniformed services.

Boston VA's Hospital Director told us that he would like to have sharing agreements with the other Federal facilities to which he is currently providing services, but that he isn't authorized to enter into such agreements. He meant that there is nothing in the VA regulations which, in his opinion, permits formal agreements with other Federal facilities. The director cited VA's "Program Guide for Sharing Specialized Medical Resources." A paragraph on "Authority to Share" mentions only community hospitals, and the director said he does not interpret this to include Federal facilities. The director emphasized, however, that he does not believe he is prohibited from providing services to other Federal facilities as long as it does not affect care for veterans, but that the sharing must be informal.

In subsequent discussions with the director's staff, it became apparent that there was a great deal of confusion over the issue of sharing agreements with Federal agencies. The director and his staff concluded that formal agreements could be made and cited two authorities. Boston VA officials said that under the first, the Economy Act, agreements could be made for general sharing of all types of services and under the second, 38 U.S.C. 5053, specialized medical resources could be shared.

West Roxbury VA's Hospital Director, also Director of VA Medical District I, favors increased Federal sharing. He has regularly attended meetings of the Tri-service Military Medical Region X, New England Subcommittee, to encourage other Federal facilities to more fully use VA hospitals. According to the director, West Roxbury VA has been accepting referrals (except dependents) informally from other Federal facilities since 1971 for all services available at West Roxbury. The director said that formal agreements with other Federal hospitals aren't needed and that there are advantages to not having them. He stated that the current informal procedure based on doctor-to-doctor referrals makes it simple to refer patients from other Federal facilities to a VA hospital.

Other hospitals in the New England area do not have the close working relationships discussed by West Roxbury's Director. For example, Newport Naval Hospital and the Providence VA Hospital are 30 miles apart but rarely share, although certain capabilities could be shared. Newport Naval Hospital refers patients to another naval hospital in Connecticut, to the PHS Hospital near Boston, or to community hospitals or air evacuates them to other military facilities. Very few patients are sent to Providence VA. In fact, several chiefs of services at Newport said they do not know what services are available at Providence VA--even though it is the closest Federal facility--never consider it for referrals, and think of VA as a completely separate system.

Even though Providence VA is operating close to capacity, some services might have been provided to patients from Newport. The Providence VA Chief of Staff reviewed a list of Navy patients that Newport had air evacuated to other military hospitals or sent to community hospitals and concluded that many could probably have been treated at Providence. Simple, clear procedures for interagency sharing which are inherent in a formal program structure would do a lot to identify possible sharing opportunities in all areas of the country and complement those instances when individual initiative has already promoted interagency sharing.

Reimbursement obstacles

Federal facilities in New England which provide services to other Federal agencies' beneficiaries do not charge full cost for services. Instead, standard interagency rates are charged. For example, in fiscal year 1977 VA hospitals billed other agencies $116 for each inpatient day and $39 for each outpatient visit, PHS billed $117 for each inpatient day and $25 for an outpatient visit, and DOD billed $168 per inpatient day and $20 per outpatient visit.

None of the providing hospitals are reimbursed nor do they receive increased allocations from their headquarters based on the reimbursements. They do, however, include services to other agencies in their workload statistics on which their subsequent years' budgets are based.

The Boston VA Hospital Director told us the lack of local reimbursement was an obstacle to sharing. However, he believed local reimbursement was made only under formal sharing agreements (38 U.S.C. 5053) involving non-Federal community hospitals.

West Roxbury VA's Hospital Director also believes that the lack of local reimbursement is an obstacle. We told him VA's Central Office returns the reimbursement to the local VA hospital under formal sharing agreements. The Director stated that this is true when the agreements are with non-Federal facilities but not with other Federal facilities. He believed that in the case of Federal facilities, reimbursement occurs only at a higher level.

Inconsistent beneficiary eligibility

Cutler refers patients to the two Boston VA Hospitals and the PHS Hospital in Brighton, Massachusetts. Cutler's policy is that active duty people will be sent to these hospitals instead of community facilities, because such services are not paid from Cutler's operating funds. On the other hand, if active duty people are sent to community facilities, Cutler must pay from its own budget. The officials also stated that they do not send dependents to the VA hospitals because VA is not allowed to accept them. However, they do send dependents, when possible, to the PHS hospital--about 45 miles away.

The PHS Hospital Director favors interagency sharing. In 1976 he added a Health Benefits Coordinator to his staff to oversee PHS use of other medical facilities. One of the coordinator's primary responsibilities is to insure that other Federal hospitals are used when possible, instead of community hospitals.

The PHS Hospital refers its beneficiaries, including dependents, to VA and community facilities primarily for specialized outpatient tests. From January to mid-May 1977, 2 PHS medical departments scheduled 302 appointments at other medical facilities. Of these, 251 were at the 2 local VA Hospitals (151 at the Boston VA and 100 at the West Roxbury VA). The remaining 51 appointments were at community hospitals. The majority of the appointments were for nuclear medicine scans. Appointments for dependents accounted for 88 of the 251 appointments.

The PHS Hospital Director stated he knew that VA, according to its regulations, was not supposed to accept dependents, but believed that VA was doing it as an accommodation to PHS. The Boston VA Hospital Director said he was not aware of this practice and he would look into it to determine the authority for doing so. Subsequently, the Boston VA Hospital's Chief of Medical Administration Services told us that VA Manual M-1, part 1, chapter 15, prohibits VA hospitals from accepting dependents. However, he then stated

that VA Regulation 6046(B)(2) applies to the dependents sent by the PHS Hospital. According to the Chief, this regulation allows VA hospitals to care for PHS beneficiaries. He stated that this means that if a PHS beneficiary is sent to the VA hospital with proper authorization and PHS will pay the bill, then the VA hospital may provide the service.

This regulation states that "Hospital care may be provided, upon authorization, for beneficiaries of the Public Health Service * * * and other Federal agencies." If the Chief's interpretation of this regulation as it pertains to PHS is correct, then it seems that the latter part of the regulation would also allow them tc accept dependents from other agencies (i.e., DOD).

Opportunities for increased sharing

As noted previously, some sharing is already occurring between the Boston area Federal medical facilities. Nevertheless, opportunities exist for more sharing even though some facilities have limited capabilities and others are already operating at close to capacity.

Air-evacuated patients

We were told by VA officials that 51 of the 62 patients air-evacuated from Cutler to other military medical facilities from October 15, 1976 to March 22, 1977 could have been treated at the West Roxbury VA or a VA psychiatric hospital at Bedford, Massachusetts. An additional 7 patients--dependents of active duty or retired personnel--could have been treated but VA said it had no authority to treat such individuals. Of these 58 patients who could have been treated locally, 43 were sent to Walter Reed Army Medical Center, about 400 miles away, and the others to various military facilities across the country.

Although we could not determine the savings which could be realized by using local Federal hospitals, we believe that routing specially equipped airplanes to military installations to pick up possibly just one patient is wasteful when that patient could have been treated at a nearby Federal facility. Additionally, according to an Air Force official, air evacuation separates the patient from his/her family and can result in the patient spending several days in transit before reaching his/her destination.

CHAMPUS patients

The Directors of both Roxbury VA and Boston PHS agreed that they could handle a larger workload, particularly in-patients, but cautioned that additional resources to support ancillary services currently operating at capacity might be required. Both Directors believed it would be much less expensive for the Government to treat Federal beneficiaries in Federal facilities than to use community hospitals.

We asked officials at both hospitals to review lists containing services provided under CHAMPUS during fiscal year 1976 in the greater Boston area. According to these officials, almost every service listed is available at one or both hospitals. Because the dates on which services were provided were not available, the directors could not say definitely that they could have provided all the services, but they indicated they could have provided many of them.

It appears that certain Federal beneficiaries currently being treated under the CHAMPUS program could be treated in other Federal hospitals.

APPENDIX V

A BILL

To assure the development and implementation of policies and procedures to make more efficient and effective use of existing Federal medical resources.

TITLE I

Section 101 - Short title

This Act may be cited as the "Federal Medical Resources Sharing and Coordination Act of 1978".

Section 102 - Findings and Purpose

(a) The Congress finds that:

(1) Unnecessarily duplicative or underutilized medical resources exist in individual Federal direct health care facilities within the same geographical area.

(2) Federal agency direct health care providers are not routinely sharing their medical resources with other Federal providers.

(3) Opportunities exist for greater interagency sharing of medical resources without any detrimental effect upon the providing agency's primary beneficiaries.

(4) Inadequate incentives currently exist within the various Federal direct health care delivery systems to make maximum use of Federal medical resources.

(5) Increased coordination among Federal agencies is needed to ensure continual availability of services to eligible beneficiaries, to maintain acceptable standards of health care quality, and to limit the effects of inflationary pressure upon operating costs by sharing Federal medical resources to the maximum extent feasible.

(b) Recognizing the need for an expeditious solution of the problems described in subsection (a), it is the purpose of this Act to (1) clarify and expand the authority for sharing medical resources among Federal agencies; and (2) facilitate the development of a comprehensive medical planning

policy for Federal agencies responsible for the provision of direct health care.

Section 103 - Definitions

As used in this Act:

(a) "Direct health care" means any health care provided to an eligible Federal beneficiary in a facility operated by the United States Government, including inpatient care and any type of outpatient treatment, test, or examination.

(b) "Beneficiary" means any individual who is entitled by law to direct health care furnished by the United States Government.

(c) "Providing agency" means any executive or military department or establishment having statutory responsibility for the provision of direct health care.

(d) "Primary beneficiary" means an individual who is among those specifically entitled by law to direct health care in the facilities of a particular providing agency.

(e) "Negotiated cost" means the cost determined on a medical service-by-service, hospital-by-hospital basis to be an equitable and consistent charge for the service(s) provided. To the maximum extent feasible this cost should include all the costs funded from current appropriations.

Section 104 - Cooperative Sharing Arrangements

(a) The Secretary of Defense, the Secretary of Health, Education, and Welfare and the Administrator of Veterans Affairs are authorized and directed, within 120 days of the effective date of the Act, to establish guidelines pursuant to which the director or commanding officer of each health care facility of such providing agency will enter into cooperative sharing arrangements under which such health care facility will be utilized, whenever appropriate, by any beneficiary eligible for direct health care.

(b) Services to be shared among Federal health care facilities will not be limited to "specialized medical resources" as defined in 38 U.S.C. 5053 and 42 U.S.C. 254a. Instead, this Act requires sharing of any medical resources which are determined by the director or commanding officer

of a Federal health care facility to be available and suitable for sharing.

(c) Such cooperative arrangements shall provide:

(1) That the availability of hospital or medical care to beneficiaries of an agency other than the providing agency shall be on a referral basis, and will not adversely affect care of the providing agency's primary beneficiaries.

(2) That the providing agency shall be reimbursed by the agency for whose beneficiary a medical service is provided. Reimbursement will be based on negotiated costs as agreed by the directors or commanding officers of the health care facilities involved.

(3) Reimbursement shall be credited when received by the providing agency to the appropriation from which the medical service was funded. The reimbursement shall be subsequently allocated to the specific facility that provided the medical service.

(d) Cooperative sharing arrangements will be negotiated and approved at the local operating level by the directors or commanding officers of the Federal health care facilities involved. Locally approved arrangements will be submitted to the respective agencies' headquarters offices for review (and disapproval if judged not to be in the best interest of the Federal Government). This requirement does not preclude facility directors or commanding officers from establishing and proceeding with agreements prior to headquarters review.

(e) Providing agencies are permitted to request funds from the Congress and to expand available funds as needed to acquire the resources necessary to treat beneficiaries of another providing agency when such actions would be in the best interest of the beneficiaries and the Federal Government.

(f) Executed cooperative sharing arrangements may be terminated within 90 days after notification in writing is given by the director or commanding officer of an involved facility.

Section 105

If any provision of this Act is inconsistent with any other provision of law insofar as it relates to dealings among Federal agencies, this Act will control.

TITLE II

FEDERAL MEDICAL CARE COORDINATION

Section 201

The Office of Management and Budget is directed to:

(1) assess the need for future development of Federal medical facilities, (2) exercise oversight responsibility for the planning of such facilities and (3) encourage and coordinate the sharing of Federal medical facilities and services to the maximum possible extent.

Section 202 - Authority and Functions

(a) The Office of Management and Budget shall provide overall direction in the form of policies and procedures for the furnishing of direct health care by the Federal Government. To the extent considered appropriate and with due regard to the program activities of the providing agencies, the Office of Management and Budget shall prescribe policies and procedures designed to maximize interagency sharing of health resources. All policies and procedures prescribed shall be followed by providing agencies in furnishing direct health care to or obtaining direct health care for their beneficiaries.

(b) The functions of the Office of Management and Budget shall include:

(1) establishing a system of coordinated, and to the extent feasible, uniform direct health care policies and procedures for the providing agencies;

(2) establishing criteria and procedures for an effective and timely method of soliciting the viewpoints of interested parties in the development of policies and procedures governing the provision of direct health care by the providing agencies;

(3) monitoring and revising policies and procedures relating to the relationships among the providing agencies; and

(4) establishing policies and procedures for coordinated planning for future development of the Federal direct health care delivery system.

(c) In developing policies and procedures to be established, the Office of Management and Budget shall consult with all affected agencies.

(d) The authority of the Office of Management and Budget under this Act shall not be construed to interfere with an agency's particular medical care responsibilities provided by law.

Section 203

The Office of Management and Budget shall annually submit to the Congress a report on the progress of Federal medical resource sharing and coordination of Federal health resources planning. Other reports may be submitted as necessary to keep the Congress informed of major Federal activities to increase sharing of Federal medical resources. Appropriate legislative recommendations shall be included in these reports.

Section 204

Each providing agency shall, upon presentation of its appropriations request for each fiscal year following the effective date of this Act, report to the committees on appropriations of the Senate and House of Representatives. The report shall detail each providing agency's activities pursuant to the cooperative sharing arrangements referred to in section 104 of this Act and other activities directed toward maximizing the efficient use of Federal health resources during the preceding fiscal year.

ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D. C. 20301

HEALTH AFFAIRS

April 5, 1978

Mr. Gregory J. Ahart
Director, Human Resources Division
General Accounting Office
Washington, DC 20548

Dear Mr. Ahart:

This is in response to your letter of January 31, 1978 to the Secretary of Defense requesting comments on a draft report entitled "Legislation Needed to Encourage Better Use of Federal Medical Resources and Remove Obstacles to Inter-agency Sharing." (OSD Case #4809) (GAO Code 10185)

The DoD supports the concepts of inter-service and inter-agency coordinated planning and delivery of health care. In this regard, the following comments are provided:

A DoD survey of the military medical departments revealed that a considerable amount of sharing already occurs among Federal health care providers. The nature of sharing agreements spans a broad range including manpower, equipment, facilities and knowledge. It includes ancilliary support services as well as direct medical services. The survey of existing sharing agreements revealed a general willingness rather than a reluctance to enter into agreements when such agreements are deemed beneficial by the activities or agencies concerned. Nevertheless, obstacles identified by the audit are real and, as the case studies reveal, frequently confound the establishment of sharing agreements. To the fullest extent possible, the obstacles should be eliminated.

As the report acknowledged, Federal health providers at the headquarters level have begun to work together in various ways, not the least of which is the creation of the Federal Health Resources Sharing Committee (FHRSC). The committee, composed of high-level representatives from the VA, USPHS, Army, Navy, Air Force and Office of the Secretary of Defense will operate under a charter tasking it to identify and promote opportunities for joint planning and use of health care resources in the Federal Government. The FHRSC is established to provide a forum for representatives from Federal agencies to interact in the cooperative exploration of joint planning and sharing opportunities in the delivery of medical services and the use of medical resources. (Attachment A) Two subcommittees have been established to explore planning and sharing opportunities and develop uniform Federal criteria and standards for cardiac catheterization laboratories and computed tomography scanner systems.

A recommendation in the report digest, page V, proposes that legislation be passed to establish a Federal policy directing inter-agency sharing of Federal medical resources "whenever appropriate." The same recommendation in the body of the report, page 55, uses the term "whenever possible." The former language is preferable in its recognition that what is possible is not necessarily appropriate.

The DoD concurs that sharing should be facilitated by enabling local hospital managers to negotiate sharing agreements under guidelines established by higher headquarters.

DoD concurs with the recommendation that the legislation permit agencies to expand services to treat beneficiaries of another Federal agency when such services would benefit the patient and the Government. The Economy Act, as pointed out in the report, has a limitation as to its effectiveness as a sharing authority in that it specifies that the providing agency must be able to provide a service without increasing its resources.

The draft report advocates the establishment of a policy requiring Federal facilities to use other Federal sources of care prior to referring patients to civilian providers or other remote distant facilities within their own health care system. The DoD concurs with the concept; however, patients should not be required to travel beyond 40 miles from their place of residence to obtain care from any source. The "40 mile radius rule" is the current guideline for issuance of non-availability statements. DoD non-concurs with the recommendation to require use of other nearby Federal hospitals prior to referring patients to other distant military hospitals. Conceptually DoD supports this policy, but on a case-by-case basis. Occasionally, a particular condition will warrant the exception because of its potential value to the military medical center and hospital teaching programs.

The GAO recommendation regarding modification of reimbursement mechanisms advances four separate proposals that represents change from existing mechanisms and will impact upon DoD. They will be addressed one at a time: (1) Base reimbursement on incremental costs. Non-concur. Reimbursement will be less complicated if based upon the recovery of full costs. In addition, a Comptroller General Decision B-136318, January 21, 1977 indicates that reimbursement for services among Federal agencies should be on the same basis as required by the User Charges Act for services provided to the general public, i.e., recovery of full costs. The GAO recommendation appears to be in conflict with that decision; (2) Establishment of fees on a service-by-service basis. Concur. When the Uniform Chart of Accounts for military hospitals, currently scheduled for full implementation on October 1, 1979, is in operation, the capability should then exist to identify costs for specific services to the degree that separate fees can be set for those services; (3) Establishment of fees on a hospital-by-hospital basis.

Non-concur. The military health care system does not operate on a fee-for-service basis since there is no requirement to recover costs for approximately ninety-nine percent of the services rendered; therefore, the system is neither now sophisticated enough, nor will it be after implementation of the Uniform Chart of Accounts, to allow rates to be established on a hospital-by-hospital basis. Rates for specific services should be centrally established; (4) Reimburse the hospital providing services. Concur that such a feature would provide more incentives to local hospital commanders to enter into sharing agreements.

In summary, the DoD is in solid agreement with the concept of sharing medical capabilities within the Federal sector. The audit report has been most helpful in focusing upon obstacles precluding further sharing. Legislation to remove such obstacles is warranted. The Federal Health Resources Sharing Committee is the most effective forum to promote sharing that results in increased effectiveness as well as economical and efficient use of Federal medical resources.

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

Sincerely,

Vernon McKenzie
Principal Deputy Assistant Secretary

Attachment (1)

GAO note: Page references in this appendix may not correspond to page numbers in this final report.

FEDERAL HEALTH RESOURCES SHARING COMMITTEE

Preamble

In recent years there have been unprecedented changes in the organization and delivery of health care in the United States. There are valid reasons to believe, moreover, that the trends demonstrated to date are only the beginning of a substantial redirection of the entire system. Burgeoning technology, rising costs, increasing consumer requirements, and fragmentation of the approach to the total health care of the individual suggest that new approaches are necessary to achieve the objectives of the health care system, both outside and within government. The Assistant Secretary of Defense (Health Affairs), the Surgeons General of the Armed Services, the Assistant Secretary for Health, DHEW (Surgeon General of the U.S. Public Health Service), and the Chief Medical Director of the Veterans Administration affirm their belief that one approach to the common objective of providing the highest possible quality of health care with greatest efficiency lies in the acceptance of common goals and an open approach to the sharing of resources. It is recognized that the broad goal of sharing resources to improve the overall quality of health care and reduce the excess consumption of scarce resources can be accomplished, in part, by coordinated planning arrangements between the signatories to this agreement.

Purpose

To identify and promote opportunities for joint planning and use of health care resources in the Federal Government. To provide a forum for representatives from Federal agencies to interact in the cooperative exploration of joint planning and sharing opportunities in the delivery of medical services and the use of medical resources. In pursuit of the primary objective of sharing Federal health resources, the Committee should consider the following:

a. Improving the quality, availability, and accessibility of patient care including patient comfort, convenience, and satisfaction.

b. Improving the efficiency with which patient care resources are expended.

c. Supporting attainment of the basic missions of Federal agencies participating in the agreement.

d. Promoting broad relationships with tertiary care institutions outside Government.

e. Promoting cooperative arrangements with non-Federal health providers, in areas of expensive specialized health services, in cooperation with health systems agencies.

f. Undertaking sharing programs in a way that supports training programs and enhances recruitment and retention of health care personnel.

g. Minimizing disruption of existing patient care and training programs.

Authority

The authority for this Committee to operate under the terms of this charter is derived from the authority vested by public laws and executive orders in the signatories of this charter.

The basic authority for sharing among Federal health care providers is established in such sources as:

31 USC 686 (Economy Act) - broad authority for interagency sharing

28 USC 5003 - facility and equipment sharing only (VA)

42 USC 254(a) - sharing specialized medical resources only (PHS)

38 USC 616 - DOD and PHS care for veterans if authorized by appropriation or other Act

38 USC 5053 - sharing specialized medical resources only (VA)

10 USC 1074(b) - VA provision of care for certain retirees only

10 USC 1074, 1076 - PHS provision of care for active duty military, retired and dependents and DOD care of other uniformed bemeficiaries

The Committee shall ensure compliance with such authorities in proposing joint programs or sharing activities.

Organization

a. Membership. Each participating Federal agency or department shall assign representatives to serve on the Committee.

b. Chairmanship. Chairmanship shall rotate annually among agencies in an order determined by the members. It shall be the responsibility of the Chairman to coordinate arrangements for meetings by conveying the time, place, and agenda to all members. The Chairman shall ensure that minutes of meetings are recorded and distributed to members. Files and pertinent records shall be maintained by the Chairman.

c. Meetings. Meetings shall be held at times and places designated by the Chairman. Meetings shall be held not less than semi-annually.

Scope of Activities

a. Define and clarify scope of "joint planning" and "sharing."

b. Advise Federal agency officials on cooperative opportunities and constraints.

c. Identify and recommend legislative, regulatory, or other policy changes to enhance joint planning and sharing.

d. Initiate, validate and recommend coordinated programs with highest payoff in reducing unwarranted duplication or excess capacity without adversely effecting efficiency, effectiveness, readiness or quality of care.

e. Constitute subcommittees to explore the feasibility of joint planning and sharing arrangements in specific health care areas and to develop criteria and standards when appropriate. To establish milestones for subcommittee compliance. Initial working groups will be:

(1) Cardiac Catheterization Laboratory Subcommittee
(2) Computerized Tomography Subcommittee
(3) Mobilization Support Subcommittee
(4) Medical Information Systems Subcommittee

f. Clarify and recommend costing and funding provisions for interagency and sharing arrangements.

g. Support appropriate interfacing with the existing mobilization expansion agreement between the VA, DOD, and PHS.

h. Periodically assess and document the scope and extent of joint planning and sharing in effect for the purpose of facilitating further sharing through an exchange of such information.

Implementation

The Committee's recommendations will be implemented through existing agency and departmental structures and processes. Recommendations will be sent to each agency for action. If a concensus has not been achieved by the Committee, all agency recommendations will be included in the minutes.

APPENDIX VI

Approval

Robert N. Smith, M.D.
Assistant Secretary of Defense
(Health Affairs)
Department of Defense

Julius B. Richmond, M.D.
Assistant Secretary for Health
Department of Health,
Education, and Welfare

John D. Chase, M.D.
Chief Medical Director
Veterans Administration

Charles C. Fixley
Lieutenant General
The Surgeon General
U. S. Army

W. P. Arentzen
Vice Admiral, MC, USN
The Surgeon General
U. S. Navy

George E. Schafer
Lieutenant General, USAF, MC
The Surgeon General
U. S. Air Force

APPENDIX VII

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20201

April 17, 1978

Mr. Gregory J. Ahart
Director, Human Resources
Division
United States General
Accounting Office
Washington, D. C. 20548

Dear Mr. Ahart:

The Secretary asked that I respond to your request for our comments on your draft report entitled "Legislation Needed to Encourage Better Use of Federal Medical Resources and Remove Obstacles to Interagency Sharing." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

Thomas D. Morris
Inspector General

Enclosure

GAO note: Page references in this appendix may not correspond to page numbers in this final report.

THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE (HEW) COMMENTS TO THE GENERAL ACCOUNTING OFFICE (GAO) DRAFT REPORT TITLED "LEGISLATION NEEDED TO ENCOURAGE BETTER USE OF FEDERAL MEDICAL RESOURCES AND REMOVE OBSTACLES TO INTERAGENCY SHARING."

GENERAL COMMENTS

The Department concurs with the general findings and recommendations of the GAO draft report. As indicated in the report, various aspects of the study have previously been coordinated with Department personnel and a number of actions which promote the broad objectives of the study have been taken. However, certain factors in the report require further development and the following comments are made to clarify specific issues contained therein:

- The report should be amended to reflect the progress made by the Federal Health Resources Sharing Committee (FHRSC). The report suggests that the FHRSC is a proposal, whereas the group has been chartered by senior officials in each agency, has organized itself and met, and has initiated study subcommittees to recommend standards for and sharing opportunities in Cardiac Catheterization Laboratories and Computerized Tomography Installations. Other subcommittees are being organized. (pp. ii, 15)

- The report tends to dismiss the work of the FHRSC before it has been given the opportunity to complete its first study. It should be recognized that a body such as the FHRSC is completely unprecedented. Its organization alone represents substantial progress, but most importantly this body has committed its sponsors to identify and overcome the largely administrative obstacles identified on pp. 20-33 of the report. Moreover, the committee represents a forum in which both existing law and new legislative proposals could be implemented. (p.iii)

- Any legislative proposal considered should clarify relationship between true primary and other Federal beneficiaries and contain a clear statement of the priority to be afforded to the primary beneficiaries. In addition, there should also be statements covering the missions of the facilities affected, patient access, convenience, quality of care, safety, and related concerns. (pp. IV, V)

- A number of questions are suggested concerning the proposal for legislation arising from the report. While there is no question that legislative relief from certain existing restrictions is necessary and that a Congressional mandate to share such as that embodied in the original Economy Act is desirable, the study should refrain from overly specific and restrictive guidelines which, while serving a need recognized today, may prove invalid later. Specifically, it

is felt that any legislation proposed should only provide permissive authority to share, the sense of the Congress that interagency sharing is a priority concern, and general reimbursement guidelines. The specific reimbursement mechanism should be left to the agencies to develop within broad general agreements negotiated by the FHRSC or similar interagency organization. The incremental cost concept discussed on p. 53 of the draft is not an ideal vehicle of reimbursement. Further, it may not be supportable by existing cost-finding and other accounting tools available to the agencies concerned. Reimbursement should occur on a cost of service basis or, in some instances, it might be desirable to share resources by means of even exchange, an action that would represent a "true" sharing of capabilities. Ultimately, such action might lead to true Federal regionalization of services such as blood banking, specialized laboratory services, or specialized radiographic or nuclear medicine facilities and equipment. Also, legislation requiring reimbursement to the hospital concerned with providing services to another agency's beneficiaries is not desirable from the standpoint of administering entire systems since it would tend to unbalance the distribution of resources and create an undesirable competition for patients and the revenues they would represent. Rather, the hospital providing services should be funded on the basis of total workload, regardless of origin, with reimbursements paid centrally to be credited against the agency's total budget. Finally on this topic, a mechanism should be created to permit the development of facilities, equipment and personnel resources on the basis of extra-agency workload, with perhaps the proviso that such budgeting (now prohibited by the Economy Act) be based on long term agreements between the contracting agencies.

- Penalties for referral to another agency, rather than CHAMPUS, should be eliminated; i.e., an agency should not be required to fund referrals to other Federal agencies out of its own resources unless its CHAMPUS referrals are paid from the same resources. However, if the service can be obtained at lower cost privately, there should be no mandate to use a more costly Federal source of care. "Disengagement" under either vehicle should not be required. (p.35)

- While the Department has no objection to centralization of sharing coordination within OMB, it is emphasized that such coordination should be a managerial rather than budget process on the basis that the latter approach is retrospective, rather than prospective, affirmative, and guiding in its approach. (p.55)

- Sharing with non-Federal beneficiaries under clearly defined conditions should be authorized. This authority, similar to that given the PHS Hospital and Clinic System in Section 328 of the PHS Act, could be used to supplement local needs in areas where excess capacity is matched by an unserved or underserved need in the surrounding community. If carefully coordinated with local planning agencies in a manner to preclude interference with local resources, such action could provide

a valuable supplement to existing local capabilities and national resources while improving utilization of Federal facilities.

The draft report also refers to the enactment of the National Health Planning and Resources Development Act of 1974 (P.L. 93-641) as recent major legislation designed to facilitate the sharing of the Nation's medical resources. The provisions of P.L. 93-641 require compliance by non-Federal hospitals and specifically exempts Federally operated facilities. However, the Department, on a voluntary basis, has subjected all Public Health Service hospital proposals (i.e. new facilities, modernizations, increased bed capacity, new special equipment) to the scrutiny of the Health Systems Agencies (HSAs) and State Health Planning and Development Agencies (SHPDAs) for ascertaining the appropriateness of such proposals. Moreover, it is not unusual for the HSAs and SHPDAs to review DOD and VA health care delivery proposals and send recommendations to the appropriate Federal agency. Both DOD and VA have informally agreed to consider the recommendations of the HSAs and SHPDAs, but they are not committed to make decisions which are in accord with the recommendations.

GAO RECOMMENDATION

We recommend that the Secretaries of Defense and Health, Education, and Welfare and the Administrator of Veterans Affairs act to:

----create an interagency task group (such as that currently being considered), made up of top-level Federal direct health care program administrators, the primary mission of which would be to encourage and expedite the implementation of a workable program of sharing Federal medical resources and

----direct the interagency task group to seek solutions to the administrative obstacles within each agency which impede the sharing of Federal medical resources.

DEPARTMENT COMMENT

We concur. The Charter of the Federal Health Resources Sharing Committee (FHRSC) has been approved by all agencies concerned. The approved charter directs the FHRSC to identify and eliminate obstacles to sharing, to prepare the FHRSC to identify and eliminate obstacles to sharing, to prepare guidelines for sharing and other cooperative arrangements for the agencies, to recommend actions to be taken when obstacles are not within the authority of the agency heads to resolve, and to establish subcommittees to deal with specific areas of concern. Initially, the FHRSC has formed subcommittees dealing with Cardiac Catheterization Laboratories and Computerized Tomography Installations. Other subcommittees dealing with Medical Information Systems and Mobilization Support are in process of formation. Reports from the Cardiac Catheterization and Computerized Tomography Subcommittees are expected by June, 1978.

VETERANS ADMINISTRATION
OFFICE OF THE ADMINISTRATOR OF VETERANS AFFAIRS
WASHINGTON, D.C. 20420
April 18, 1978

Mr. Gregory J. Ahart
Director, Human Resources Division
U. S. General Accounting Office
441 G Street, NW
Washington, DC 20548

Dear Mr. Ahart:

We appreciate the opportunity to comment on the January 31, 1978 General Accounting Office (GAO) draft report, "Legislation Needed to Encourage Better Use of Federal Medical Resources and Remove Obstacles to Interagency Sharing." All aspects of the report have been carefully reviewed and we offer the following comments.

In response to the recommendations to the Secretaries of Defense (DOD), and Health, Education and Welfare (HEW), and the Administrator of Veterans Affairs (VA) that we act to:

—Create an interagency task group (such as that currently being considered), made up of top-level Federal direct health care program administrators, the primary mission of which would be to encourage and expedite the implementation of a workable program of sharing Federal medical resources, and

—Direct the interagency task group to seek solutions to the administrative obstacles within each agency which impede the sharing of federal medical resources,

we would like to emphasize that the Department of Medicine and Surgery (DM&S) has provided impetus and direction in the development of a coordinated approach to health services planning by Federal agencies.

Initial meetings were held in the Office of the Assistant Chief Medical Director for Professional Services on August 4, August 8, and September 12, 1977, to explore joint Federal planning and sharing of specialized medical resources. Major discussion focused on establishing the organizational entity and the functional role of the task group. Subsequent meetings were held during November 1977, January, February and March 1978. The original group has been expanded by the addition of representatives of the three military services and the designation of the Deputy Assistant Secretary of Defense for Health Resources and Programs as the DOD representative. A formal charter developed for what is now called the Federal Health Resoures Sharing Committee (FHRSC) has been officially approved within each Agency.

The fast maturing role of the FHRSC is reflected in the positive actions being accomplished. Four initial study subcommittees are being established to formulate the basis for sharing decisions concerning cardiac catheterization, computerized tomography, mobilization support and medical information systems. Over time, the subcommittees are expected to develop standards for Federal providers in their designated field, to identify areas for potential sharing, and to present recommendations to the full Committee for sharing decisions. A consolidated list of existing interagency sharing arrangements is being assembled as a basis for further sharing considerations.

Administrative remedies for many of the reported impediments to interagency sharing are feasible without the need for further legislation. To the extent that there is inconsistency in the application of policies and procedures by individual health care facilities, as indicated by some of the cited case studies, this can be readily corrected by a redrafting and republication of VA policies and regulations to remove possible ambiguities and insure uniform interpretation and application.

This draft report also contains recommendations that the Congress enact legislation which would:

--Establish a policy that directs interagency sharing of Federal medical resources whenever possible.

--Authorize each Federal health provider to accept all categories of direct care beneficiaries on a referral basis when it would be advantageous to the Federal Government and care of primary beneficiaries would not be adversely affected.

--Eliminate all restrictions on the types of medical services which can be shared between Federal facilities.

--Grant field hospital managers approval authority for arrangements between Federal facilities subject to headquarters veto only if judged not in the best interests of the Government.

--Permit agencies to expand services to treat beneficiaries of another Federal agency when such services would benefit the patient and the Government.

--Establish a policy requiring Federal facilities to use, if practical, other nearby Federal direct health care resources prior to referring patients for care under programs such as CHAMPUS, CHAMPVA, or to other distant facilities within their own health care system.

--Establish a standard method of reimbursement based on incremental costs between Federal hospitals with a provision to reimburse the hospital which provided the services to other Federal agencies' beneficiaries. This reimbursement mechanism would allow Federal hospital officials to agree upon equitable fees on a service-by-service, hospital-by-hospital basis.

In the same vein as our comments on the recommendations to DOD, HEW and the VA, and as recently testified to during the House Hearings on the VA 1979 budget request, the relatively new Interagency Committee on coordination and sharing of medical resources appears to offer an ideal mechanism for removing misunderstandings between and cooperation by the respective agencies involved.

We are opposed to the recommendation to establish a standard method of reimbursement based on incremental costs between Federal hospitals with a provision to reimburse the hospitals which provided the services. It is our position that reimbursement should be on actual costs which represent an average, uniform system rate, and not incremental or "out-of-pocket." The Agency's billing should not be based on two rates, one for Federal beneficiaries and another for non-Federal institutions. This could actually serve as a disincentive to sharing. If this recommendation becomes a part of the report, we feel the impact of such action should also be included. An incremental or "out-of-pocket" billing in lieu of actual costs will considerably reduce the amount of reimbursements presently being earned.

It should also be noted (see page 828 of the Appendix to the Budget For Fiscal Year 1979) that one of the Administrative Provisions related to VA appropriations states that, "No part of the foregoing appropriations shall be available for hospitalization or examination of any persons except beneficiaries entitled under the laws bestowing such benefits to veterans, unless reimbursement of cost is made to the appropriation at such rates as may be fixed by the Administrator of Veterans Affairs. (Department of Housing and Urban Development--Independent Agencies Appropriation Act, 1978)." Further, every appropriations act since the 1940's has contained the identical or a similar provision.

There are some other points we would like to bring out and ask that you consider including or correcting them in the final report.

In the section entitled, "LEGISLATIVE AUTHORITIES FOR SHARING FEDERAL MEDICAL RESOURCES," we feel credit for the VA's earlier efforts in interagency cooperation would be appropriate. Three examples follow:

--For many years, veterans were regularly admitted to the Philadelphia Naval Hospital if the 488 bed VA facility could not treat them.

--For a number of years there was a joint Bureau of the Budget/DOD/VA/HEW team responsible for reviewing future construction in the light of possible interagency cooperation.

--In the mid-1960's the Public Health Service (PHS) and VA worked together very well, with VA hospitals admitting PHS beneficiaries who no longer had access to Marine Hospitals which were closed (e.g. Chicago, Detroit, Memphis).

The section, "Time-consuming review of proposed sharing agreements," contains the statement, "the approval process can take more than 60 days if difficulties are encountered." While this is accurate in some instances--and all the case studies used by GAO in this report were problem situations--our average time for approval remains 21 work days. We do not believe this represents "time-consuming review."

Corrections should be made in the "Lack of standard reimbursement mechanism" section, because it indicates that only Interagency Agreement Reimbursements are to be deposited in a Treasury Account. All reimbursements collected must be deposited to a Treasury account. Reimbursements resulting from Interagency Agreements have been estimated--included in total anticipated workload--and funding has been allocated in advance in the Annual Target Allowance for each facility. Therefore, they are not available for reallocation as collected during the fiscal year. But anticipated reimbursements to be realized through Sharing Agreements are retained in a Treasury reserve account, (not allocated in advance in the Annual Target Allowance), and refunded quarterly, upon request, to the servicing facilities as reimbursements are collected.

The decision for this procedure did not occur 10 to 12 years ago and was not to make the budgeting process easier. In FY 1956, the Department of Medicine and Surgery adopted the Annual Target Allowance

System. This required the allocation of funds and workloads to each facility on an annual basis. To implement this new procedure, Total Budget Authority, plus anticipated reimbursements, became the base against which facility annual target allowance levels were established. It must be assumed that in the initial year of the annual target allowance consideration was given to the source of the reimbursements in making the distribution to each facility. Therefore, we do not feel that any maldistribution of the reimbursements ever existed.

Also in this report section, we would like to clarify that the redistribution, which totaled $33 million in FY 1977, is subject to adjustment from year to year based on workloads, rates and other known factors. This redistribution includes amounts "earned" under sharing agreements (offset by services purchased under sharing agreements), adjustments for exceeding or falling short of anticipated workload (which includes interagency agreements), and costs of furnishing reimbursable services to other VA appropriations or funds.

We wish to refute the statement in CHAPTER 3, CONCLUSIONS AND RECOMMENDATIONS, that the VA lacks an effective reimbursement mechanism and is inconsistent in its application. The VA seeks reimbursement for services rendered other Federal facilities in two ways—either by an Interagency Agreement or a Sharing Agreement. In both instances, actual costs are realized in accordance with present legislation. The method is negotiated at the facility level and forwarded to VA's Central Office for review and approval. We feel the present system is sound, but a reiteration of present policy could be helpful to all facility directors.

It has been our purpose up to this point to address specific issues or comments in the report. We believe we would be remiss, however, if we did not also address some of the basic policy issues which are associated with the recommendations contained in this report, or would affect their implementation.

The American people, acting through the President and the Congress, repeatedly have evidenced a special concern for its citizens who devoted part of their lives, usually their youth, to the defense of their country. Medical care has long been one of the primary areas where special care to veterans is provided. Originally, that care was provided by many components of the Federal government, as well as by some of the State agencies. In 1930, the establishment of the Veterans Administration consolidated these services into one Federal agency with a medical service responsible for all activities associated with the medical care and treatment of veterans, and in January 1946, Public Law 293 of the 79th Congress, created the Department of Medicine and Surgery within the Veterans Administration, and made it responsible for what has become the largest medical and hospital care system solely for the treatment of veterans.

By law, the VA is clearly responsible for providing complete care for veterans with service-connected disabilities. Its responsibility for nonservice-connected disabilities is primarily to veterans who are unable to pay for such care in other facilities.

The recommendations in this report seem to favor an amalgamation of resources for beneficiaries in the Federal sector. We are not unmindful of the need for cost containment, nor are we unmindful that additional efforts within the Federal sector may be able to accomplish a better utilization of resources. Any action we take, however, must be in accord with our primary mission of caring for veterans. Any new endeavor to share our resources, either within the Federal or the private sector, can only be considered if we are assured that it will not adversely affect our ability to accomplish our statutory obligation.

There is currently much controversy about how the nation's health care services should be obligated, delivered, and financed. Despite considerable pressure for change, there is still no agreement on which direction the change should take to produce the most desirable results. We realize that if a national health insurance program is established within the next few years, an important question will arise concerning the VA's role in that program. Because of this, and the fact that the President is still considering all of the options with respect to providing for the health care needs of the nation, as well as how the VA medical care system can best fit into the plans for the future, we believe it would be unwise to proceed immediately with legislation implementing the recommendations contained in this report. We also believe, as has been indicated, that administrative measures under way, or within reach, may be preferable to the legislative steps which the recommendations would entail. Finally, we cannot support the management and funding concepts advocated in the recommendations. It is our opinion that they are not in accord with accepted and recognized Federal agency management principles, and may be inadequate as a matter of law.

Again, we express our appreciation for the opportunity afforded us to comment.

Sincerely,

MAX CLELAND
Administrator

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

March 21, 1978

Mr. Gregory J. Ahart
Director
Human Resources Division
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

I am pleased to comment on your draft report, "Legislation Needed to Encourage Better Use of Federal Medical Resources and Remove Obstacles to Sharing."

This Office shares concern over many of the problems discussed in your report about sharing among Federal agencies. Your report is comprehensive, making many recommendations for extensive legislative and fiscal, as well as programmatic change. Lacking detailed analysis of the recommendations, and their potential impact, we cannot at this time indicate a position on the changes recommended for congressional consideration. However, we disagree with your recommendation that OMB establish a full-time staff group to work with the Federal agencies on improved sharing. I do not feel that this Agency should create a specific new unit solely for this purpose. Our full-time budget examiners and other OMB staff already work with the concerned agencies on a daily basis carrying out our role of budgetary and legislative analyses. This process allows us to explore individual and interagency issues and to recommend actions which are consistent among the agencies. Also, through our current process we can address interagency problems within the important focus of larger agency and national needs. A small, single-purpose unit would not be as efficient or effective as our current process, and for this reason, I feel we must approach this problem through our current organization.

I want to assure you that your report will be of great assistance to us in considering further actions to address sharing problems.

Sincerely,

W. Bowman Cutter

W. Bowman Cutter
Executive Associate Director
for Budget

APPENDIX X

PRINCIPAL OFFICIALS RESPONSIBLE FOR ACTIVITIES DISCUSSED IN THIS REPORT

	Tenure of office From		To	
DEPARTMENT OF DEFENSE				
SECRETARY OF DEFENSE:				
Harold Brown	Jan.	1977	Present	
Donald H. Rumsfeld	Nov.	1975	Jan.	1977
ASSISTANT SECRETARY (HEALTH AFFAIRS):				
Vernon McKenzie (acting)	Jan.	1978	Present	
Robert N. Smith, M.D.	Sept.	1976	Jan.	1978
Vernon McKenzie (acting)	Mar.	1976	Sept.	1976
James R. Cowan, M.D.	Feb.	1974	Mar.	1976
DEPARTMENT OF THE ARMY				
SECRETARY OF THE ARMY:				
Clifford L. Alexander, Jr.	Feb.	1977	Present	
Martin R. Hoffman	Aug.	1975	Jan.	1977
THE SURGEON GENERAL:				
Lt. Gen. Charles C. Pixley	Oct.	1977	Present	
Lt. Gen. Richard R. Taylor	Oct.	1973	Oct.	1977
DEPARTMENT OF THE AIR FORCE				
SECRETARY OF THE AIR FORCE:				
John C. Stetson	Apr.	1977	Present	
Thomas C. Reed	Jan.	1976	Apr.	1977
James W. Plummer (acting)	Nov.	1975	Jan.	1976
THE SURGEON GENERAL:				
Lt. Gen. G. E. Schafer	Aug.	1975	Present	
DEPARTMENT OF THE NAVY				
SECRETARY OF THE NAVY:				
W. Graham Claytor, Jr.	Feb.	1977	Present	
J. William Middendorf II	June	1974	Feb.	1977
J. William Middendorf II (acting)	Apr.	1974	June	1974

APPENDIX X

	Tenure of office From	To
DEPARTMENT OF THE NAVY (continued)		
THE SURGEON GENERAL:		
Vice Adm. William P. Arentzen	Aug. 1976	Present
Vice Adm. Donald L. Custis	Mar. 1973	July 1976
DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE		
SECRETARY OF HEALTH, EDUCATION, AND WELFARE:		
Joseph A. Califano, Jr.	Jan. 1977	Present
David Mathews	Aug. 1975	Jan. 1977
ASSISTANT SECRETARY FOR HEALTH:		
Julius B. Richmond, M.D.	July 1977	Present
James Dickson, M.D. (acting)	Jan. 1977	July 1977
Theodore Cooper, M.D.	May 1975	Jan. 1977
Theodore Cooper, M.D. (acting)	Feb. 1975	Apr. 1975
VETERANS ADMINISTRATION		
ADMINISTRATOR OF VETERANS AFFAIRS:		
Max Cleland	Mar. 1977	Present
Richard L. Roudebush	Oct. 1974	Mar. 1977
Richard L. Roudebush (acting)	Sept. 1974	Oct. 1974
CHIEF MEDICAL DIRECTOR:		
John D. Chase, M.D.	Apr. 1974	Present

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