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VA Health Care

Efforts to Increase Sharing With DOD and the Private Sector

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Health, Education, and Human Services Division

GAO/T-HEHS-96-41

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss the status and future direction of Department of Veterans Affairs' (VA) health care resources sharing with the Department of Defense (DOD) and the private sector.

Health resources sharing, which involves the buying, selling, or bartering of health care services, can be beneficial to both parties in the agreement and helps contain health care costs by making better use of medical resources. For example, it is often cheaper for a hospital to buy an infrequently used diagnostic test from another hospital than it is to purchase the needed equipment and provide the service directly. Similarly, a hospital that is using an expensive piece of equipment only 4 hours a day but is staffed to operate the equipment for 8 hours could generate additional revenues by selling its excess capacity to other providers.

In the past 15 to 20 years, we have conducted a series of reviews that have identified barriers to greater sharing,[1] problems in administering sharing agreements, and the benefits and risks involved in expanding VA's authority to share resources with the private sector. My comments this morning are based on the results of those reviews, interviews with VA and DOD officials, and review of reports on sharing prepared by the two agencies.

Specifically, we will discuss

-- the origin and evolution of VA's sharing authority,

-- the growth in sharing agreements, and

-- challenges facing VA as it enters into more and more sharing agreements with the private sector.

RESULTS IN BRIEF

Since 1966, the Congress has broadened the types of services, beneficiaries, and providers that can be covered under VA sharing agreements, eased burdensome reimbursement provisions that discouraged VA facilities from developing sharing agreements, and allowed providing facilities to retain funds from shared services as an incentive to use excess capacities.

As a result, the number of VA facilities with sharing agreements with DOD facilities increased from 12 in 1983 to 147 in 1995. Every VA facility within 50 miles of a DOD health care facility now has one or more sharing agreements. VA has about

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[1]A list of related GAO testimonies and reports is in appendix I.

seven times as many agreements to provide services as it does to acquire services from DOD. By contrast, VA buys about three times as many specialized medical services from private-sector facilities as it sells.

The monetary benefits of VA/DOD sharing agreements are often difficult to quantify. VA and DOD reports on sharing do not contain data on the extent to which sharing agreements are actually used, and agency officials say few services are actually exchanged under some agreements. The recent agreement under which VA's Asheville, North Carolina, medical center provides services to CHAMPUS beneficiaries at a 5-percent discount below what DOD would otherwise pay private-sector providers, however, illustrates the potential benefits of sharing.

The recent expansion of VA sharing to include service to CHAMPUS beneficiaries, the participation of VA facilities as providers under DOD's TRICARE program, and the proposed expansion of VA private-sector sharing create challenges for VA. For example, VA facilities will have to comply with billing, utilization review, and quality assurance requirements imposed by CHAMPUS, TRICARE contractors, and private-sector health plans if it wants to serve their beneficiaries.[2] Similarly, VA facilities will face difficult choices on when to provide health care services directly and when to contract for such services. Although VA currently lacks much of the financial and utilization data needed to facilitate such critical decisions, it is implementing a Decision Support System (DSS) that should better enable VA to generate itemized health care bills and monitor the quality and quantity of care provided in its facilities.

BACKGROUND

VA provides health care services to eligible veterans through 173 hospitals and about 200 freestanding clinics. In fiscal year 1994, VA provided health care services to about 2.5 million veterans at a cost of about $15.4 billion. VA provided about 1 million inpatient stays and approximately 24.4 million outpatient visits. While outpatient workload is generally increasing, acute care hospital workload is decreasing, dropping by over 50 percent during the past 25 years. As a result, many VA hospitals have excess capacity.

DOD operates 124 hospitals and over 500 clinics, providing care to active-duty personnel and, on a space-available basis,

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[2]Utilization reviews assess the need for and appropriateness of health care services. Quality assurance refers to programs designed to ensure that patients receive high-quality health care.

other eligible beneficiaries.[3] The number of DOD health care facilities is decreasing as part of the downsizing and infrastructure reductions occurring in DOD. Like VA facilities, many DOD hospitals have significant amounts of excess physical capacity.

In addition to the direct care system, DOD administers an insurance-like program called the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). CHAMPUS helps pay for medical care for nonactive-duty beneficiaries under age 65 by civilian hospitals, physicians, and other civilian providers.[4]

DOD's medical programs provide health care benefits to 1.7 million active-duty military personnel and another 6.6 million nonactive-duty beneficiaries. The total fiscal year 1995 cost of the DOD health care delivery system is over $15 billion--$11.6 billion for direct care services and another $3.6 billion for CHAMPUS.

DOD is restructuring the military health care system into a managed health care program known as TRICARE. Under TRICARE, a managed care support contractor establishes an integrated network of military and civilian health care providers and offers CHAMPUS beneficiaries a triple-option health care benefit.

Beneficiaries remain eligible for the standard CHAMPUS benefit, referred to as TRICARE Standard. Under TRICARE Standard, beneficiaries pay deductibles and from 20 percent to 25 percent of the cost of their care, depending on their eligibility. A second level of benefit is TRICARE Extra. TRICARE Extra beneficiaries pay a reduced copayment when they choose a medical provider participating in the contractor's TRICARE network. The third option available is TRICARE Prime. As in a civilian health maintenance organization, beneficiaries may choose to enroll in TRICARE Prime, which provides comprehensive medical care through the contractor's integrated network of military and contracted civilian providers. TRICARE

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[3]People eligible for military health care are active-duty members of the uniformed services, family members of active-duty military personnel, retired military personnel and their family members, and family members of deceased military personnel or retirees. The uniformed services are the Army, Navy, Air Force, Marine Corps, Coast Guard, and the Commissioned Corps of the Public Health Service and the National Oceanic and Atmospheric Administration.

[4]At age 65, beneficiaries lose their CHAMPUS eligibility and become eligible for Medicare.

Prime beneficiaries pay low enrollment fees and copayments but must go through an assigned military or civilian primary care provider for all of their care.

Implementation of the program began in March 1995, and DOD expects to have TRICARE in place across the country by May 1997.

ORIGIN AND EVOLUTION OF HEALTH RESOURCES SHARING

To allow federal agencies' resources to be used to maximum capacity and avoid unnecessary duplication and overlap of activities, federal agencies have been authorized for over 60 years to obtain goods or services through another federal agency.[5] The law permits two federal hospitals to enter into an interagency agreement for goods and services as long as the hospital providing the services is reimbursed the actual cost, the services are available, it is in the best interest of the government to do so, and the services cannot be provided as conveniently or cheaply by nongovernment agencies.

VA's sharing authority was expanded to include sharing with nonfederal hospitals, clinics, and medical schools in 1966.[6] This authority, however, had several important limitations. First, it was limited to sharing of "specialized medical resources," medical techniques, and education. Such resources included equipment, space, or personnel, which, because of cost, limited availability, or unusual nature, are either unique in the medical community or can be fully used only through mutual use. Second, VA was to be reimbursed the full cost of services provided under specialized medical resources sharing agreements. Finally, sharing agreements negotiated under this authority were not to diminish the services to eligible veterans.

Although these laws permitted federal interagency sharing, they did not clearly require such sharing. In 1978,[7] we reported that the following significant barriers precluded or discouraged federal agencies from sharing:

-- In the absence of a specific legislative mandate for interagency sharing, VA had little headquarters guidance on how to share.

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[5]31 U.S.C. 1535, 1536.

[6]Public Law 89-785, 38 U.S.C. 8151-57.

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

-- Agency regulations, policies, and procedures based on each agencies' existing legislative authority inhibited interagency sharing.

-- Inconsistent and unequal methods for agencies to be reimbursed for services rendered to other agencies' beneficiaries gave hospital officials little incentive to share.

The first major step in addressing these barriers occurred in 1982 through enactment of the Veterans Administration and Department of Defense Health Resources Sharing and Emergency Operations Act.[8] To encourage development of sharing agreements at the local level, the act stipulated that a sharing agreement negotiated by DOD and VA hospital officials would go into effect automatically unless disapproved by headquarters officials within 46 days. The act also (1) modified the prior requirement that the providing agency recover its costs of providing shared services and gave the VA authority to take into account local conditions and needs and (2) required that local facilities' allotments be credited for services provided under sharing agreements to provide an incentive for facilities with excess capacity to share medical resources.

To promote VA/DOD sharing, the act established the VA/DOD Health Care Resources Sharing Committee, composed of the Assistant Secretary of Defense for Health Affairs, VA's Under Secretary for Health, and other agency officials designated by them. The following year, VA and DOD completed a memorandum of understanding beginning the VA/DOD sharing program.

Six years after the enactment of the VA/DOD sharing act, we found that while significant progress had been made in encouraging interagency sharing, the following barriers remained:[9]

-- Local VA and DOD officials did not understand that reimbursement rates could be set at less than total costs to encourage sharing.

-- DOD's budgetary procedures for allocating resources to its medical facilities did not guarantee that an individual facility's allocation would be increased by the amount of VA reimbursements, discouraging some military hospitals from entering into sharing agreements with VA.

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[8]Public Law 97-174, 38 U.S.C. 8111.

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

-- The sharing law did not allow VA to treat the dependents of active-duty and retired members of the uniformed services.

-- Military hospitals were reluctant to refer DOD beneficiaries to VA hospitals because they could not use CHAMPUS funds to pay for the care. In other words, the cost of referring a patient to a VA hospital would come out of the military hospital's funds, but the costs of referring a patient to a civilian provider would come out of CHAMPUS funds.

In 1989, the Congress enacted legislation specifically authorizing the use of CHAMPUS funds to reimburse the VA for care for CHAMPUS beneficiaries from VA medical centers under sharing agreements.[10] Three years later, in 1992, the Congress enacted a temporary expansion of authority for sharing agreements that permits the treatment of all categories of DOD beneficiaries at VA hospitals.[11]

Despite these congressional actions, differences between VA and DOD over provisions of a memorandum of understanding continued to prevent CHAMPUS beneficiaries from receiving services in VA hospitals through CHAMPUS. These differences centered mainly on whether VA's hospitals would be treated as military hospitals or as CHAMPUS civilian providers. VA wanted its hospitals to be treated as military hospitals, which involve no copayments or deductibles. In addition, it wanted to (1) bill DOD directly rather than submit bills through CHAMPUS fiscal intermediaries, (2) bill CHAMPUS on a per diem basis rather than use CHAMPUS' diagnosis-related group (DRG) system, and (3) use its own utilization management and quality review systems. DOD, on the other hand, wanted VA facilities to follow CHAMPUS procedures for seeking reimbursement by filing claims with CHAMPUS fiscal intermediaries and collecting copayments and deductibles from beneficiaries.

In October 1993, the former Chairman of the House Committee on Veterans' Affairs intervened to resolve the disagreement. After this, both parties signed a sharing agreement in December 1993 to treat CHAMPUS-eligible beneficiaries in the Asheville, North Carolina, VA medical center. Under the agreement, the Asheville VA medical center is treated as a CHAMPUS provider instead of a direct care provider, it collects CHAMPUS copayments and deductibles, and it bills through CHAMPUS fiscal intermediaries. CHAMPUS reimburses claims submitted by the Asheville VA medical center for inpatient charges at a 5-percent discount off the amount payable to civilian providers under the

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[10]National Defense Authorization Act Fiscal Years 1990 and 1991.

[11]Veterans Health Care Act of 1992.

CHAMPUS DRG system. DOD similarly receives a 5-percent discount off the CHAMPUS maximum allowable charge for professional services.

A broader agreement was reached in February 1994 providing a framework for future CHAMPUS/VA health care resource-sharing agreements. Additional CHAMPUS/VA sharing agreements are being developed in Indiana and New York.

The advent of DOD's TRICARE program ushered in a new era in VA/DOD sharing, largely supplanting VA/CHAMPUS sharing. On June 29, 1995, VA and DOD completed work on an agreement that allows VA facilities to compete with private-sector facilities to serve as providers under TRICARE contracts. Like private-sector providers, VA facilities will be allowed to apply to DOD's regional managed care support contractors to serve as TRICARE providers. VA facilities will be required to meet the same cost, quality, and access criteria as private-sector providers and be subject to the same utilization management and quality assurance requirements as other contractors. VA facilities would essentially become subcontractors to a DOD contractor.

Provisions in the proposed Veterans Reconciliation Act of 1995, recently approved by the House Committee on Veterans' Affairs, would further expand VA's authority to share health care resources with the private sector. Specifically, it would

-- remove the current provision that limits services that can be shared with the private sector to specialized medical resources;

-- broaden the types of entities with whom VA can share to include any health care provider, health care plan, insurer, or other entity or individual;

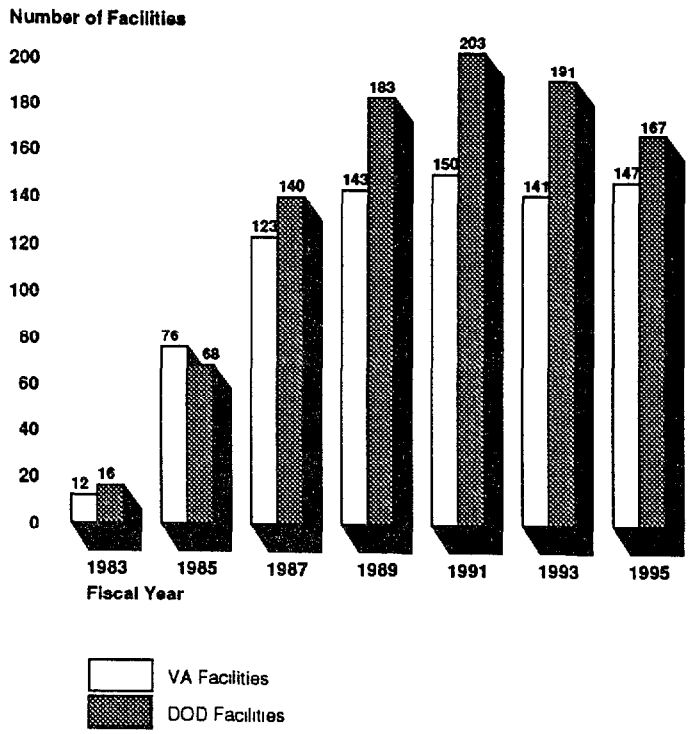
-- replace the requirement that reimbursement rates be based on actual costs of shared services with a general requirement that VA negotiate payments that are in the best interest of the government.

SHARING OF MEDICAL RESOURCES INCREASING

As barriers to sharing have been identified and addressed, VA sharing both with DOD and with the private sector continues to grow. The number of VA medical facilities with VA/DOD sharing agreements increased from 12 in 1983 to 147 in 1995. Similarly, the number of DOD facilities involved in sharing agreements increased from 16 in 1983 to a peak of 203 in 1991. Because of the closure of DOD medical facilities due to downsizing, the

number of DOD facilities with sharing agreements declined to 167 by 1995. All VA medical centers within 50 miles of a DOD hospital currently have sharing agreements. (See fig. 1.)

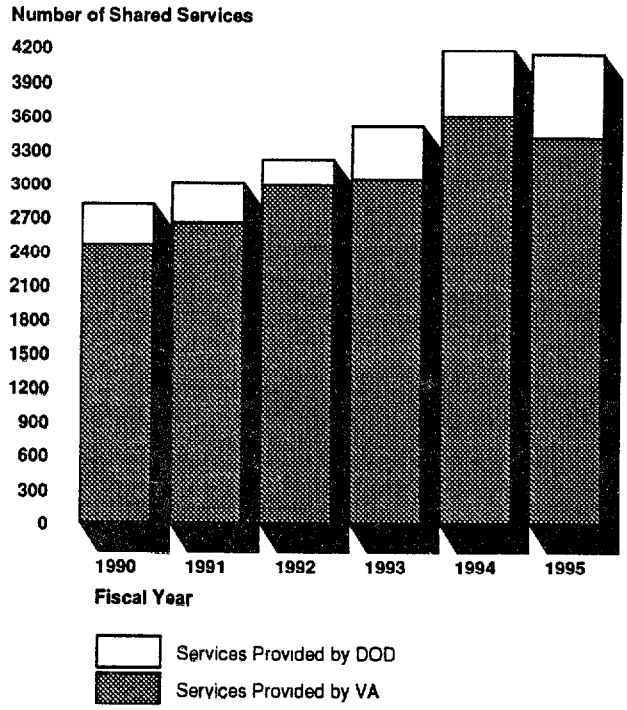
Figure 1: Number of Facilities With VA/DOD Sharing Agreements (1983-95)



Note: Facilities may be hospitals or clinics.

The total number of services covered by VA/DOD sharing agreements increased from 2,815 in 1990 to 4,133 in 1995. (See fig. 2.) Most of the sharing agreements involve DOD acquiring services from VA. The portion of shared services to be provided by VA averaged over 87 percent. DOD attributes this imbalance to the fact that many of its hospitals are significantly smaller than nearby VA hospitals. In general, these smaller hospitals are more often in the position of buying services than of providing them to other facilities.

Figure 2: Total Services Covered by VA/DOD Sharing Agreements (1990-95)



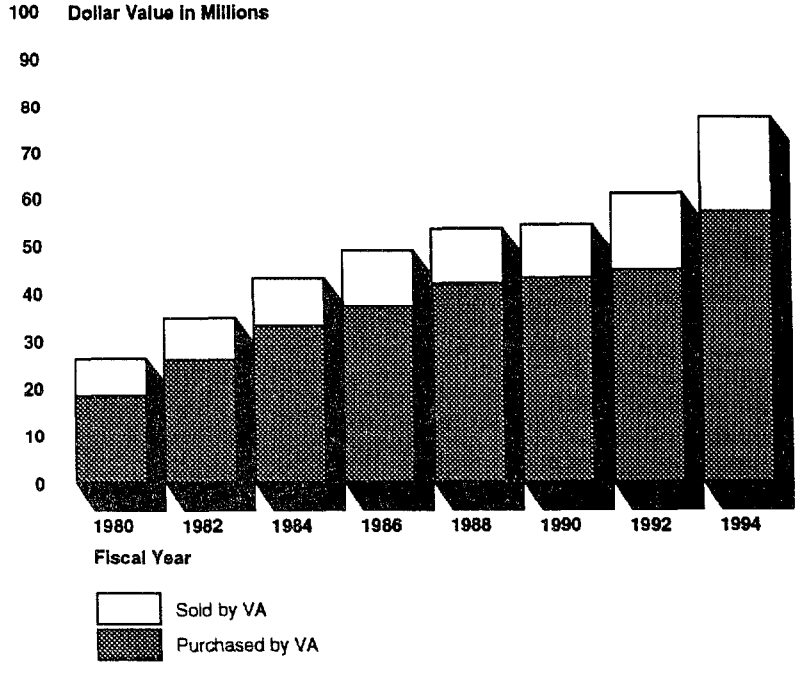
Most of this activity reflects agreements that local hospital officials initiated. Hospital-to-hospital agreements cover a range of hospital services, with most sharing involving ancillary services such as laboratory tests or diagnostic radiology procedures. Although the number of sharing agreements and the number of services covered under those agreements has grown substantially, neither VA nor DOD reports on the sharing program provide data on the volume of services actually provided.[12] Agency officials told us that some agreements generate little or no activity.

[12]At the request of the Chairman, House Committee on Veterans' Affairs, we are using a questionnaire to determine the volume of services provided to DOD beneficiaries and other nonveterans.

Specialized Medical Resources Sharing

Sharing of specialized medical resources, primarily with affiliated medical school hospitals, has also increased. Between 1980 and 1994, the value of shared services increased from $26 million to $77 million. Unlike sharing with DOD in which VA generally sold services, specialized medical resource sharing more commonly involves VA's purchasing services from outside providers. For example, VA reported that in fiscal year 1994 it purchased $56.8 million worth of services from other hospitals and sold services worth $20.3 million. (See fig. 3.) Diagnostic radiology services accounted for the greatest dollar value, $3.9 million, of services provided by VA in fiscal year 1994. VA's largest expenditures were for radiation therapy, at slightly under $20 million.

Figure 3: Dollar Value of VA Specialized Medical Resource-Sharing Activity (1980-94)



EXPANDED SHARING WITH PRIVATE SECTOR CREATES CHALLENGES

As VA increasingly provides services to nonveterans in VA facilities through sharing agreements and expands contracting with private-sector facilities and health plans to provide health care services to veterans, VA faces many challenges. As a seller, VA will need to meet the billing, utilization review, and quality assurance requirements of CHAMPUS, TRICARE, and private-sector health plans. In addition, it will need to set prices for its services that will make it competitive with private-sector providers without detracting from its ability to meet the needs of veterans. As a buyer, VA will need to determine when it is more economical to buy services or provide them directly, how to strengthen contract administration, how to set capitation payments when it buys services on a risk basis, and how to ensure the quality of the services it buys. However, actions by the Asheville VA medical center to develop billing procedures acceptable to CHAMPUS and allow outside utilization and quality assurance reviews demonstrate the ability of VA to address and meet such challenges.

VA Facilities Will Likely Be Required to Permit Outside Utilization and Quality Assurance Reviews

VA will likely be unable to contract to provide services to CHAMPUS beneficiaries, TRICARE contractors, or private-sector health plans and facilities unless it complies with oversight requirements established by those programs. Like private sector hospitals, VA hospitals are reviewed and accredited by the Joint Commission on Accreditation of Healthcare Organizations. But, unlike private sector hospitals, VA generally does not allow private insurers or others to perform utilization or quality-of-care reviews at its hospitals.

One of the conditions DOD placed on VA before allowing the Asheville VA medical center to contract to provide services to CHAMPUS beneficiaries was that the medical center agree to adhere to CHAMPUS utilization review and quality review systems.[13] Under the agreement reached between VA and DOD, the Asheville medical center will maintain its own utilization and quality assurance system, but it will also be subject to CHAMPUS utilization review and quality assurance requirements. Similarly, the recently completed memorandum of understanding

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[13] VA/DOD Health Care: More Guidance Needed to Implement CHAMPUS-Funded Sharing Agreements (GAO/HEHS-95-15, Oct. 28, 1994).

governing VA's participation under the TRICARE program provides that VA facilities be subject to the contractor's utilization and quality assurance requirements.

New Billing Methods Would Be Needed

One of the primary barriers VA encountered in entering into a sharing agreement to treat CHAMPUS beneficiaries was its inability to generate itemized bills and to bill using DRGs. When VA bills insurance companies, it bills on a per diem basis; that is, it bills a fixed amount per day regardless of the specific services provided.[14] Similarly, it charges a fixed fee for an outpatient visit regardless of the number or types of services provided.

DOD officials told us that a condition placed on VA's participation in the CHAMPUS program was its ability to produce an itemized bill like that required of other CHAMPUS providers. A stand-alone billing system was created at the Asheville VA medical center to allow the center to enter into a CHAMPUS sharing agreement. Similar billing systems will likely need to be established at other medical centers if VA is to contract to provide services under TRICARE or through private health plans.

VA is currently implementing a DSS that will enable VA to generate itemized bills at all of its medical centers. DSS has the potential to be an effective management tool for improving the quality and cost-effectiveness of VA health care. We recently reported, however, that VA has not yet developed the comprehensive business strategy necessary to achieve such potential benefits.[15] We noted that some of the data provided to DSS from other VA information systems are incomplete and inaccurate, limiting VA's ability to rely on DSS-generated information to make sound business decisions. Because of problems in ensuring the accuracy of data entered into the system, we recommended that VA slow the implementation of DSS.

Lack of Accurate Cost Data Creates Problems in Setting Prices

VA needs accurate cost data to determine appropriate prices to charge for items and services sold to private-sector facilities or health plans. If prices are set too low, funds

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[14]Separate per diem rates are used for medical, surgical, and psychiatric care.

[15]VA Health Care Delivery: Top Management Leadership Critical to Success of Decision Support System (GAO/AIMD-95-182, Sept. 29, 1995).

from other sources would be needed to subsidize losses, and less money would be available to provide services to veterans. VA facilities generally cannot generate accurate cost data on items and services they provide.

The specialized medical resources sharing law does not really specify how VA is to price the medical resources it provides to medical schools, health care facilities, and research centers. The law states that reimbursement must be based on a methodology that provides appropriate flexibility to the heads of VA facilities after accounting for local conditions and needs and the actual cost of the resource involved to the providing facility.

We reported in December 1994 that the Albuquerque VA medical center sold lithotripsy services to the University of New Mexico at a price less than half of its cost of providing the service.[16] We noted that the medical center's pricing practices for procedures provided to the University may affect the competitive balance among health care facilities in the Albuquerque area because the University, benefiting from VA's low reimbursement rates, was setting charges to its patients significantly below market rates. The University's reduced rates may likely shift market demand from other area hospitals to the University. Although VA agreed that the Albuquerque medical center was not recovering the full cost of lithotripsy services and that its price-setting methodology was flawed, it does not believe the rates should be increased to recover full costs.

If VA sets its prices too low because it (1) cannot determine accurate costs or (2) wants to capture market share, funds appropriated to provide care for veterans may be used to subsidize private-sector facilities and health plans purchasing services from VA. This could ultimately lead to veterans being denied needed health care services.

The lack of accurate cost data also makes it difficult for VA facilities to determine when to contract for services rather than provide them directly. Unless VA acts to improve the completeness and accuracy of data provided to DSS from other VA information systems, the usefulness of DSS-generated data in making such basic business decisions will be limited.

Overcoming Problems in Administering Contracts

VA has a long history of problems in administering specialized medical services contracts. For example, in a 1987

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[16] VA Health Care: Albuquerque Medical Center Not Recovering Full Costs of Lithotripsy Services (GAO/HEHS-95-19, Dec. 28, 1994).

audit, VA's Inspector General reported that VA medical centers had awarded contracts for more services than were needed, paid for services they had not received, and had not established controls to ensure that contractor performance and billing complied with contract terms.[17] Our July 1992 followup to the Inspector General's report found that VA still lacked sufficient data and evaluation criteria to ensure that problems were identified and corrected.[18]

Because VA medical centers' senior managers often receive part-time employment incomes from medical schools that receive millions of dollars through VA contracts, conflicts of interest could arise. In April 1993, we reported that these managers nevertheless participated in awarding or administering contracts with medical schools.[19] Although VA has taken steps to improve the administration of sharing contracts, the effectiveness of these efforts in preventing future problems is unknown. The expanded contracting envisioned under TRICARE and the Veterans Reconciliation Act of 1995 will likely increase opportunities for conflicts to arise.

Quality Assurance Under Capitation Creates New Challenges

VA is increasingly looking to contract with individual physicians, groups of physicians, or health plans to provide health care services to veterans, often on a capitation basis. Such contracts heighten the need for VA to develop effective mechanisms to ensure the quality of services provided. Specifically, it would need to ensure that physicians are properly licensed, establish utilization reporting requirements for providers or health plans paid on a capitation basis, and establish utilization review programs to detect underservicing by risk-based providers.

Quality assurance is a particular concern under risk-based contracts because the same financial incentives that contractors have to limit unnecessary health care utilization can provide the contractor an incentive to deny needed health care services. That is, the contractor may "underserve" beneficiaries to maximize profits. Managed care programs that have been in

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[17] Audits of Selected Aspects of VA's Program for Sharing Scarce Medical Resources, Report No: 7AM-A99-089, July 15, 1987.

[18] VA Health Care: Inadequate Controls Over Scarce Medical Specialist Contracts (GAO/HRD-92-114, July 29, 1992).

[19] VA Health Care: Inadequate Enforcement of Federal Ethics Requirements at VA Medical Centers (GAO/HRD-93-39, Apr. 30, 1993).

operation for many years, such as Arizona's Medicaid program, have developed utilization review programs that detect both overuse and underuse of health care services.

Setting Capitation Rates Will Be Difficult

Accurate cost and utilization data are critical in setting capitation payments to risk contractors. Rates set too high could result in excess profits for providers selling services to VA and increased costs for the government. Rates set too low, however, could affect the solvency of the risk contractors and lead to underservicing of veterans.

VA does not have adequate data on health care utilization to enable it to establish reasonable capitation payments to private-sector providers. VA knows the number of episodes of inpatient care and of outpatient visits, but the following problems limit the usefulness of these data in setting capitation payments:

-- Because veterans do not currently enroll in the VA health care system, VA has utilization data for users but does not know how many other veterans would have used VA if they needed care. Without knowing how many other veterans would have relied on VA for health care services if they had needed care, VA will find that setting accurate capitation rates by using past VA utilization is difficult.

-- VA does not know the extent to which current users rely on VA for their health care services. Over half of the Medicare-eligible veterans who used VA health care services in 1990 also used non-VA providers under Medicare. Without knowing the full health care utilization of those likely to be covered by VA capitation payments, VA will have little basis for estimating potential demand for care and setting capitation payments. In addition, to the extent that VA makes capitation payments for care to be provided to veterans covered by and using other federal health care programs, the government could end up paying twice for the same health care services. For example, if veterans covered by capitation agreements obtain services covered under the capitation agreement from other providers who subsequently bill the government under Medicare, then the government will have paid two different providers for the same care.

CONCLUSIONS

Health care resources sharing offers many benefits both to those providing and those obtaining the shared service. For those providing the service, sharing provides the opportunity to more fully utilize certain medical resources. By making its excess capacity available to others, a facility can lower its

average cost of providing services to its beneficiaries. Similarly, by purchasing services from another provider or facility, VA may be able to obtain services at a lower cost to the government than it would incur in providing the services directly. Although the benefits are hard to quantify, expanded sharing of excess health care resources should be encouraged.

Although the primary legislative barriers to increased sharing have been overcome, new barriers and challenges have emerged as the scope and types of sharing arrangements evolve and the focus of sharing shifts more toward contracting with private providers and health plans. As long as sharing is focused on the exchange of services between federal facilities, the recovery of full costs is not important. But, if VA provides services under a private contractor, as planned under TRICARE, or to private-sector facilities or health plans, pricing becomes more important. If VA does not recover its cost of providing services to nonveterans under these programs, it could result in fewer funds being available to serve veterans.

The establishment of a CHAMPUS sharing agreement in Asheville and plans to establish such agreements at two other medical centers demonstrate the ability of VA to respond to challenges such as developing itemized bills and complying with health plan utilization review and quality assurance requirements. In addition to expanding sharing opportunities, these actions should help improve the overall efficiency of VA operations.

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Mr. Chairman, this concludes my prepared statement. We will be happy to answer any questions that you or other Members of the Committee may have.

For more information on this testimony, please call Jim Linz, Assistant Director, at (202) 512-7110, or David Lewis, Evaluator-in-Charge, at (202) 512-7176.

(101482)

RELATED GAO PRODUCTS

VA Health Care Delivery: Top Management Leadership Critical to Success of Decision Support System (GAO/AIMD-95-182, Sept. 29, 1995).

VA Health Care: Challenges and Options for the Future (GAO/T-HEHS-95-147, May 9, 1995).

Barriers to VA Managed Care (GAO/HEHS-95-84R, Apr. 20, 1995).

VA Health Care: Albuquerque Medical Center Not Recovering Full Costs of Lithotripsy Services (GAO/HEHS-95-19, Dec. 28, 1994).

VA/DOD Health Care: More Guidance Needed to Implement CHAMPUS-Funded Sharing Agreements (GAO/HEHS-95-15, Oct. 28, 1994).

Veterans' Health Care: Efforts to Make VA Competitive May Create Significant Risks (GAO/T-HEHS-94-197, June 29, 1994).

VA Health Care Reform: Financial Implications of the Proposed Health Security Act (GAO/T-HEHS-94-148 May 5, 1994).

VA Health Care: Inadequate Enforcement of Federal Ethics Requirements at VA Medical Centers (GAO/HRD-93-39, Apr. 30, 1993).

VA Health Care: Inadequate Controls Over Scarce Medical Specialist Contracts (GAO/HRD-92-114, July 29, 1992).

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

Sharing of Federal Medical resources in North Chicago/Great Lakes, Illinois, Area (GAO/HRD-81-13, Oct. 6, 1980).

The Congress Should Mandate Formation of a Military-VA-Civilian Contingency Hospital System (GAO/HRD-80-76 June 26, 1980).

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

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