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STATEMENT OF
GREGORY J. AHART, DIRECTOR, HUMAN RESOURCES DIVISION
BEFORE THE
SENATE COMMITTEE ON GOVERNMENTAL AFFAIRS
ON
[Comments on S. 2958,
A BILL TO ENCOURAGE FEDERAL AGENCIES
TO SHARE MEDICAL RESOURCES
ON AN INTERAGENCY BASIS]

Mr. Chairman and members of the Committee, we are pleased to be here today to discuss S. 2958, a bill to encourage Federal agencies to share medical resources on an interagency basis.

We share the concern, expressed in your remarks in introducing this bill, that if the Congress is going to succeed in balancing the budget in fiscal year 1981 and beyond without jeopardizing essential services to American citizens, every effort must be made to eliminate waste and inefficiency in Government. In our opinion this bill constitutes a legislative statement of policy and guidance needed by the Federal Government's two largest direct health care systems--the Department of Defense (DOD) and the Veterans Administration (VA)--to more efficiently spend the billions of dollars appropriated annually to them for construction and renovation of health care facilities, purchase of medical supplies and equipment, and medical personnel.

This legislation addresses the obstacles to interagency sharing of medical resources identified in our report "Legislation Needed to Encourage Better Use of Federal Medical Resources and Remove Obstacles to Interagency Sharing" (HRD-78-54, June 14, 1978).

We believe that 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 which provide care not available from the DOD, VA, and the Public Health Service. Perhaps the best example of such a program is DOD's CHAMPUS 1/ program, which is expected to cost over $800 million in fiscal year 1981.

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

Also, beneficiaries might be able to be treated in Federal facilities closer to their residences and might themselves save money because they would not be required to pay specified portions of the cost of care.

The following examples taken from our June 1978 report are typical of the cost savings and improved patient care opportunities--as well as the obstacles to their implementation--which we believe exist throughout the Federal health care sector.

For several years, the San Diego Naval Hospital referred patients to a community facility for laser treatment of a 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. Long delays in scheduling Navy personnel on the community laser finally led hospital personnel to seek use of the San Diego VA laser unit.

1/Civilian Health and Medical Program of the Uniformed Services.

San Diego VA's response was enthusiastic and it offered to let Navy use the laser twice a week at no cost. However, in subsequent discussions with VA's Central Office, San Diego VA officials were told that a fee was needed and that it would be highly unlikely that any no-fee contract would ever be approved. San Diego VA personnel were surprised by this opinion, because there would have been no real additional local costs. The laser was used for research, and Navy was going to use it on off-time.

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 then $39 interagency rate specified for all outpatient visits. The $39 was to be charged for each treatment, while the price the Navy paid in the community was an initial $50 charge with no subsequent charges for additional treatment.

The VA's Central Office eventually disapproved the proposed sharing agreement because, in addition to the question of proper charge, an incorrect title for the agreement was used and the wrong authority for sharing with the Navy had been cited. As a result the Navy has bought its own laser unit for $28,500.

Also, 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, 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 civilian providers--but wanted to explore the possibility of using VA's laboratory. VA would have benefitted by an increased workload, which would (1) enhance the resident training program, and (2) further justify the laboratory's existence.

The lack of incentives to share as well as no provision for any reimbursement back to the providing hospital eventually resulted in the failure to enter into a sharing arrangement.

BACKGROUND

Over the years, increasing concern has been expressed in the Congress and elsewhere over the rapidly increasing costs of medical care. As in the private sector, Federal agencies' costs to provide health care directly to eligible beneficiaries

have continued to rise, and efforts have been made by the Federal agencies to explore ways of reducing these costs without adversely affecting the quality of care provided to Federal beneficiaries.

In fiscal year 1980, about $10 billion of congressional appropriations were requested by the Government's major direct health care providers. Other Federal agencies, such as the Departments of State, Justice, and Agriculture, requested additional tens of millions of dollars for health care services.

The rising cost of health care is particularly important to DOD and VA officials because of their responsibilities for providing health care directly to the majority of eligible Federal beneficiaries. These agencies spent an estimated $9.1 billion in fiscal year 1979 to provide medical care to their beneficiary populations. Hundreds of millions of these dollars were for care provided outside the Federal Government's direct health care systems.

Until recently, each Federal agency planned its health delivery system in terms of having sufficient services for the beneficiaries for which the agency had primary health care responsibility without considering the needs and capabilities of other Federal agencies.

However, Congressional desire for greater sharing was expressed in the Heart Disease, Cancer, and Stroke Amend-

ments 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 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 and nongovernmental agencies, organizations, and groups concerned with health services, facilities, or manpower.

In addition, the National Health Planning and Resources Development Act of 1974 (Public Law 93-641, 42 U.S.C. 300 et seq.) required 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 VA, DOD, and the Department of Health and Human Services' (HHS') direct health care systems was required.

Recognizing the unprecendented changes in the organization and delivery of our Nation's health care, a unified position on interagency sharing was taken by high-level representatives of the Government's major direct health care systems. In early 1978, the Assistant Secretary of Defense

(Health Affairs), the Surgeons General of the Armed Services, HHS's Assistant Secretary for Health, and VA's Chief Medical Director agreed that one approach to providing the highest possible quality of care with the greatest efficiency was to accept common goals and share resources. A Committee called the Federal Health Resources Sharing Committee (Sharing Committee) was established in February 1978. Its broad goal was to improve the overall quality of health care and reduce the excess consumption of scarce resources through coordinated planning arrangements.

The Sharing Committee committed itself to identify and promote opportunities for jointly planning and using the Government's health care resources. It provided a forum for agency medical representatives to cooperatively explore opportunities to share services and resources.

The Committee developed its scope of activities to include the following:

--Define and clarify the scope of joint planning and sharing.

--Advise Federal agency officials on cooperative opportunities and restraints.

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

--Initiate, validate, and recommend coordinated programs that give the highest payoff in reducing unwarranted

duplication or excess capacity, but avoid adversely affecting efficiency, effectiveness, readiness, or quality.

--Clarify and recommend costing and funding provisions for interagency sharing agreements.

--Establish subcommittees to explore joint planning and sharing arrangements in specific health care areas and develop criteria standards, when appropriate.

To accomplish its goals and objectives, the Sharing Committee has used several legislative authorities which permit Federal interagency sharing. However, in our opinion, these authorities do not give agency officials the uniform and comprehensive legislative guidance needed to implement a full and effective interagency medical resources sharing program.

For example, the Economy Act, 31 U.S.C. 686, permits a Federal hospital 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. In regard to the sharing of medical resources, the statute is permissive, except for three limitations: (1) both hospitals must be Federal hospitals, (2) the providing facility must be reimbursed on the basis of actual costs, and (3) the providing agency must be able to provide the service without increasing its resources. The Economy Act represents the only broad authority

under which military hospitals may provide medical services to other agencies' beneficiaries.

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 under 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 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.

As part of its standard operating procedures, the Sharing Committee has established subcommittees to (1) develop and propose guidelines and criteria for assessing and justifying the need for and appropriate location of specialized medical services, (2) develop and propose program utilization criteria, and (3) explore sharing opportunities in specific geographic areas. Such subcommittees include the Cardiac Catheterization Laboratory Subcommittee, the Computerized Tomography Subcommittee, and the Cancer Treatment Facility Subcommittee.

In January 1980, the Chairman of the Sharing Committee approved the establishment of a Legislation Subcommittee. Its purpose was to provide the Sharing Committee with a review of the existing impediments to resource sharing along with recommended actions for removing these barriers where possible. The Subcommittee members represented the Army, Navy, Air Force, Department of Defense (Health Affairs), Public Health Service, and the Veterans Administration. Between January 25 and July 2, 1980, the Subcommittee held 18 meetings to complete its assigned tasks. A final Subcommittee report to the Sharing Committee was issued in July 1980.

GAO REPORTS ON INTERAGENCY SHARING OF MEDICAL RESOURCES

Our Office has invested considerable staff resources during the past 5 years in dealing with issue of sharing of Federal health care resources.

Some of the more specialized and highly expensive medical resources capable of being shared among Federal agencies have been discussed in our reports. Other reports have focused on the need to build new DOD and VA hospitals of proper size. The sizes of such new facilities should be dependent on the ability of Federal hospitals in immediate geographic areas to make effective use of existing resources, thereby avoiding the expenditure of additional Federal funds for unnecessary construction. Appendix I to this statement lists our reports which directly and indirectly address opportunities for interagency sharing of Federal medical resources.

Many of our reports concern matters ultimately considered by the Sharing Committee in its attempt to implement an effective sharing program among its member agencies. However, the Sharing Committee-directed efforts over the past 2 1/2 years by the many medical and administrative support personnel from DOD, VA, and HHS have not, in our opinion, resulted in substantive progress in implementing an effective Federal interagency sharing program. However, its efforts are continuing.

This is not to say that no sharing is taking place between individual health care facilities in the Federal sector. For example, Army data for fiscal year 1979 indicate that the Army facilities provided VA beneficiaries with about $7.4 million

of inpatient and outpatient services. This total was based on a total of 26,594 inpatient days reimbursed at a DOD interagency rate of $253 per day and an additional 27,755 outpatient visits reimbursed at the DOD interagency rate of $25 per visit. The Tripler Army Medical Center in Hawaii accounted for a large portion--14,656 inpatient days and 15,422 outpatient visits--of this total.

There is an incomplete data base for ascertaining the total services provided among Federal facilities. The Sharing Committee has recognized this situation and has called for Federal facilities to report on both the types and dollar values of shared services.

It is important to note that this is being accomplished in the absence of a legislatively established environment which specifically encourages sharing. S. 2958 would establish such an environment, this in turn could pave the way for substantially increased sharing of direct medical care resources. The sharing of medical resources--particularly the more specialized and expensive--has the potential for significantly larger pay-offs in terms of budget savings to the Government and the taxpayers.

OBSTACLES TO SHARING

The basic reasons for the overall lack of substantive progress being made in taking advantage of the sharing opportunities were identified in our June 1978 report "Legislation

Needed to Encourage Better Use of Federal Medical Resources and Remove Obstacles to Interagency Sharing."

Our report was requested in January 1977 by the Chairman of the House Appropriations Committee. In addition to asking us to identify opportunities for Federal health care providers to share their resources, we were asked to identify legislative and administrative obstacles which may preclude sharing. The Chairman 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 have existed in the geographic areas we reviewed.

In most instances, one or more of 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 policy 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 Sharing Committee are hindered by the same types of obstacles.

Lack of Specific Legislative and Adequate Headquarters Guidance

Although numerous laws authorize beneficiaries from one Federal agency to be treated in another Federal agency's facility, none are explicit concerning what categories of beneficiaries can be served. Of the laws, the Economy Act (31 U.S.C. 686) could probably best be used to share. Other laws 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. This condition exists to some extent because the Congress has not enacted legislation which clearly specifies its expectations concerning interagency sharing.

For example, in June 1976 the Conference Report on DOD's 1977 military construction appropriations request provided policy guidance to DOD--which had 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 has helped DOD plan 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.

In essense, the Congress has told DOD to share with other Federal agencies, but has given no legislative authority to supplement the Economy Act to accomplish this task. The Congress has not provided (1) legislation to require interagency sharing when appropriate or (2) uniform guidance to all Federal agencies on sharing.

Because of this lack of a legislative policy, Federal agencies have been unable to establish an effective Federal interagency medical sharing program. In agency officials' opinions, the individual health care systems were established to serve specific beneficiaries. Some agency officials believe that to provide extensive care for another Federal agency's beneficiaries could adversely affect their abilities to perform their primary missions. In an overall sense (and notwithstanding the work of the Sharing Committee) interagency sharing has been given low priority within Federal agencies and, as might be expected, there are currently no

uniform policies, regulations, or procedures. Therefore, little consistent guidance is provided by the headquarters or command levels to hospitals or clinics attempting to enter into interagency sharing agreements.

Restrictive Regulations Policies, and Procedures

Agency regulations, policies, and procedures, based on each agency's interpretation and implementation of existing legislation, inhibit interagency sharing. During our review, we identified several instances where Federal hospitals could have shared services but did not 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 direct health care agencies. PHS' sharing authority, however, is restricted similarly to VA's.

DOD restrictions on treating VA beneficiaries

As previously mentioned, the only broad 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 regulations place restrictions on VA's beneficiaries being treated in Army facilities. While authorizing care for eligible beneficiaries of other Federal agencies on a reimbursable basis under the authority of the Economy Act, the regulations limit Army inpatient care for VA beneficiaries to emergencies and cases where beds have been allocated by prior agreement. Navy and Air Force regulations place similar restrictions on treating VA beneficiaries.

Also Army regulations regarding outpatient care for VA beneficiaries are not clear. One regulation states that outpatient care, other than in emergencies, must be authorized in advance. The Army Health Services Command's Chief of Patient Administration at the time of our review 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 the Army really had no specific mission to treat VA beneficiaries.

This mission argument was raised in many of our discussions with agency officials. 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, in our opinion, VA has interpreted the Economy Act's authority rather narrowly and inconsistently.

During our review, a VA Central Office official told us that dependents of active duty and retired military personnel could be treated in VA hospitals 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 a VA hospital had negotiated an interagency agreement under the Economy Act.

However, one of the interagency agreements in effect at the time of our review specified that active duty and retired military and their dependents, both men and women, would be eligible for cardiac catheterization in a VA hospital. This agreement, under the Ecomomy Act's authority, was inconsistent with what the VA Central Office official told us.

In response to our inquiry regarding this and other apparent inconsistencies in its application of sharing authorities, the Administrator of Veterans Affairs stated that its hospitals were authorized to provide medical services to all beneficiaries of other Federal agencies under the

Economy Act. However, 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 capability to provide a requested service for other agencies' beneficiaries is administrative and may be expected to constantly fluctuate in direct relationship to veterans' care needs.

VA concluded that since it was not in a position to provide medical services to eligible dependent beneficiaries, it must contract for such services. Therefore, VA believed our questions concerning authority to share and the basis for recovery of costs under such arrangements were essentially moot. However, as we pointed out to the Administrator, VA hospitals were servicing active duty and retired military members and their dependents in several locations. In no instances were these services, according to the VA hospital officials involved, being provided to the detriment of VA's primary beneficiaries.

Overall, we found that VA's regulations restrict other Federal agencies' beneficiaries from receiving routine medical care. 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 authoried by the appropriate military 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. 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 have 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. VA Central Office officials also believed that sharing restrictions need to be relaxed.

Budgetary restrictions

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

Another budgetary obstacle relates to the several alternative means DOD has for treating its own beneficiaries which favorably affects an individual military facility's health care budget but ultimately negatively affects possible opportunities to share Federal medical resources. These alternative means involve using CHAMPUS and transferring patients to other DOD facilities using the domestic areomedical evacuation system. 1/

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

The availability of the CHAMPUS alternative 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 any uniformed service medical facility.

Generally, for non-emergency inpatient treatment these patients must obtain a certificate stating that needed care is not available in any local uniform military facility within a 40-mile radius. CHAMPUS is funded under a separate DOD appropriation from that financing the operation of the facility issuing the nonavailabaility 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, referral of military beneficiaries to another Federal facility for treatment would likely involve a charge which would come out of the local military hospital's budget.

A similar lack of incentive exists in some instances when DOD hospitals use the domestic aeromedical evacuation system. The Air Force transports military beneficiaries from one military medical facility to another, and military medical

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 thereby creating an incentive for DOD hospital officials to rely on this alternative rather than referring patients to nearby VA facilities on a reimbursable basis.

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.

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 should 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 interest. The local authority could, however, involve the necessary participants without having to wait long periods of time for Central Office review.

Inconsistent and Unequal Reimbursement Methods

Perhaps the 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.

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 costs, 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 costs. 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 Title 38 sharing agreement, is required under the Economy Act.

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 Title 38 sharing authority (38 U.S.C. 5053) rather than under an interagency sharing agreement under the Economy Act.

Essentially, to furnish a "carrot" encouraging VA's sharing, services provided under formal sharing agreement authority could result in double payment to the local hospital since (1) a patient referred from another facility is counted in the workload statistics used to request funds from the Congress with subsequent allocations to the hospital and (2) VA allocates total reimbursements for services provided under sharing agreements back to the providing hospital. On the other hand, services provided 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 the expenses incurred.

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. 38 U.S.C. 5053, is used primarily by the VA for sharing with the private sector hospitals. However, Federal hospitals are permitted to share under this authority.

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. The Army, for example, does not allow any direct local reimbursement. Navy allows a partial reimbursement of outpatient charges and Air Force indirectly reimburses its facilities through the budget process. 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 procure services from other Federal agencies (e.g., VA) only on the basis of interagency rates. Full cost and interagency rates are rarely the same. As a consequence, sharing between these Federal agencies is limited because of their failure to arrive at mutually agreeable reimbursement rates.

Officials of the Army, Navy, and Air Force told us that unlike the VA's insistence on actual costs, the military departments require interagency rates for both purchasing and providing direct care and supplemental care to other Federal agencies.

GAO Prior Recommendations to Implement an Effective Interagency Medical Resources Sharing Program

In our June 1978 report we concluded that the Federal Government has a unique opportunity to take the lead in medical resources sharing. We believed that to take full advantage of this opportunity, however, required 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 direct health care systems administered by DOD, VA, and the Public Health Service.

We strongly believe that the legislative and administrative obstacles to sharing can 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 its health care beneficiaries.

After careful consideration of various alternative recommendations to overcome the obstacles we identified, we felt the paramount need was for legislation to require interagency sharing when appropriate and to encourage the establishment of Government-wide implementing procedures. Such legislation would encourage individual initiative without adversely affecting any Federal agency's current responsibilities or organizational and command structures. It would also give increased management options to local Federal medical officials to make the best use of our Nation's medical resources.

We recommended, therefore, 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 providing facility's 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 interest to 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 or CHAMPVA 1/ 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.

--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.

GAO's Views on S. 2958

We believe that enacting legislation which establishes a 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 in view of the

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1/Civilian Health and Medical Programs of the Veterans Administration.

increasing concern regarding the spiraling costs of health care.

S. 2958 addresses the factors we believe are essential to the implementation of an effective interagency medical resources sharing program. Enactment of this 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.

Many S. 2958 provisions would carry out the intent of the legislative proposal presented in our June 1978 report and are important and necessary to accomplishing the bill's purpose.

Before addressing specific sections of the bill, I would like to suggest that the Committee include the Department of Health and Human Services in the bill, and also include the Department's Secretary as a member of the Sharing Committee envisioned by S. 2958. We recognize that DOD and VA represent the majority of the Federal Government's direct health care resources and are responsible for the provision of health care to the largest segments of the Federal beneficiary population. Nevertheless, HHS, through its Public Health Service and Indian Health Service direct health care systems, provides care to a substantial Federal beneficiary population,

including many persons with current or future eligibility for care in military and/or VA facilities. We believe that the inclusion of HHS would further enhance your proposal for the implementation of an effective interagency medical resources sharing program.

Our specific comments on several of the bill's provisions follow:

--Section 2. (a)(4) recognizes the importance of each agency's current responsibilities, and therefore, its mission. This is important to the agencies and we believe the agencies' implementation of this legislation would enhance the ability of each agency to seek and obtain alternative sources of care for the beneficiaries while controlling rising health care costs.

--Section 2. (b) states that the purpose of this Act is to expand and clarify the authority of the VA and DOD as direct health care providers in order to facilitiate Federal interagency sharing of medical care and medical care support resources. This section is important because the resources to be shared would not be limited to direct medical services, but would include the ancillary support services (i.e. administrative, laboratory, laundry, etc.) needed by Federal direct health care providers.

--Section 3. (5) defines "negotiated costs" as the cost for services provided between Federal facilities as determined

by local hospital officials on a medical service-by-service, hospital-by-hospital basis in an equitable and consistent manner.

We believe a "negotiated" cost rather than an "actual", "full" or "reasonable" cost as currently provided for in existing sharing legislation is needed if an effective sharing program is to be implemented. These latter categories of costs do not necessarily represent the true "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.

Any reimbursement mechanism adopted by the agencies 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 depending on individual circumstances, 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. As HHS suggested in commenting on the draft of our June 1978 report, it might even be desirable to share resources by means of even exchange (no reimbursement). In any case, if the reimbursements are agreeable to both parties, sharing will take place.

Also, as provided in Sec. 4. (a)(6)(F) the reimbursement must be credited to the specific facility which provided the medical service. Without such a provision, the incentive at the local Federal hospital level to share is diminished or lost. In addition, the same subsection allows funds received as reimbursement for services provided to be obligated in the fiscal year following the fiscal year in which the medical service was provided. We endorse this provision because without it funds received from sharing arrangements would have to be obligated within the same fiscal year the medical resource is shared. This could cause administrative problems near the end of each fiscal year and thereby reduce the incentive for local facilities to foster continuing sharing programs. This provision should also obviate the need for possibly substantial end-of-year spending of proceeds from sharing arrangements.

As the agencies' willingness to share their resources increases and their cost accounting systems become more sophisticated, it seems reasonable to expect that incremental costs could eventually become the standard basis of reimbursements for medical resources shared between Federal agencies.

--Section 4(a) of the bill establishes a Federal Interagency Health Resources Committee to coordinate the interagency sharing of medical resources. The Committee would be comprised of the Secretary of Defense and the Administrator

of Veterans' Affairs. These officials would be held accountable by the Congress for fulfilling the responsibilities contained throughout Section 4 of S. 2958.

In our recommendation to the Congress for implementing an effective Federal medical resources sharing program, we recommended that responsibilities similar to those contained in Sec. 4 be assigned to the Office of Management and Budget (OMB). However, OMB has consistently taken the position that the more formal oversight and coordination we recommended was not necessary. Instead, OMB, when considering interagency sharing issues, prefers to rely on its budget examiners and other staff already working with the affected agencies.

S. 2958 clearly delineates Congressional policy on the issue of sharing medical resources and specifies that the Federal Interagency Health Resources Committee's primary responsibility is to fully and effectively implement this congressional policy. The formal congressional recognition of the Committee as the leader in this interagency effort satisfies the intent of our report recommendation.

--Section 4. (c) permits the agencies to request from Congress relief from personnel ceilings or other restrictions as well as funding needed to treat other Federal agencies beneficiaries. Such requests must be substantiated by the providing agency.

We endorse the personnel ceilings relief provided by this bill. However, such relief should be used in a prudent manner and only in instances when it would be cost-effective to the Federal Government as a whole. Our field work has indicated that personnel ceilings are a major impediment to the sharing of medical resources among Federal agencies.

We believe that if Government agencies are to effectively, efficiently, and economically accomplish the programs and functions authorized by the Congress, they must judiciously use the most appropriate kinds of manpower capable of producing the desired results. There is general agreement that civilian and military employment must be controlled, but opinions differ about the effectiveness of different control techniques.

We have suggested that funding or program limitations seemed to be an effective means of controlling the number of persons an agency can employ. Additional controls imposed by personnel ceilings deprive agency management of options for accomplishing activities such as interagency sharing through the most effective, efficient, and economical arrangements. In our opinion, the bill's requirement for specific justification of such requests is sufficient to insure proper use of staffing and other resources.

Moreover, we believe additional funding should, as the bill permits, be authorized upon specific justification that

it would be most cost-effective to treat beneficiaries of one agency in direct health care facilities of another agency.

Finally, the focus of S. 2958 and our testimony have pertained to the establishment of a strong peacetime medical resources sharing program. However, a closely related issue involves the extent of support VA can provide DOD in treating battlefield casualties. Our recently issued report "The Congress Should Mandate Formation of a Military-VA-Civilian Contingency Hospital System" (HRD-80-76, June 26, 1980) discusses this important issue.

The most important issue in this report relative to sharing Federal medical resources is that VA believes it cannot fully support DOD in treating casualties expected to return to duty without legislative modification to its current responsibilities. In fact, the Administrator of Veterans Affairs recently told DOD that VA would not be able to directly support DOD in treating wartime casualties in the United States unless it is given that mission in other than a declared national emergency.

We believe that a contingency hospital system which makes use of VA's medical resources for all categories of returning casualties would be an efficient and effective use of Federal medical capability. Moreover, we believe that a strong peacetime medical resource sharing program, such as S. 2958 mandates, could provide a sound foundation for

establishing effective working relationships between VA and DOD. Such a program would be invaluable in the event of war.

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We continue to believe the Federal Government has a unique opportunity to take the lead in medical resource sharing and to serve as a model for proper health resources planning and use. In our opinion, the Congress' enactment of S. 2958 would represent a significant step forward in that direction by creating an environment in which Federal agencies could make the most cost-effective use of their medical resources while maintaining, or perhaps enhancing, the quality of care provided to their many beneficiaries.

This concludes my statement. We will be happy to answer any questions you might have.

GAO REPORTS DEALING WITH OPPORTUNITIES FOR SHARING OF FEDERAL MEDICAL RESOURCES

"Policy Changes and More Realistic Planning Can Reduce Size of New San Diego Naval Hospital" (MWD-76-117, April 7, 1976)

"Congressional Policy Guidance Should Improve Military Hospital Planning" (HRD-77-5, Nov. 18, 1976)

"Many Cardiac Catheterization Laboratories Under-used in Veterans Administration Hospitals: Better Planning and Contrtol Needed" (HRD-76-168, Feb. 28, 1977)

Letter Report on "VA's Process to Determine Size of New and Replacement Health Care Facilities" (HRD-77-104, May 20, 1977)

Letter Report on "Operation of PHS Hospitals and Clinics as Required by Public Law 93-155" (HRD-77-111, May 26, 1977)

"Sharing Cardiac Catheterization Services: A Way to Improve Patient Care and Reduce Costs" (HRD-78-14, Nov. 17, 1977)

"Computed Tomography Scanners: Opportunity for Coordinated Federal Planning Before Substantial Acquisitions" (HRD-78-41, Jan. 30, 1978)

"Constructing New VA Hospital in Camden, New Jersey Unjustified" (HRD-78-51, Feb 6, 1978)

"Inappropriate Number of Acute Care Beds Planned by VA for New Hospitals" (HRD-78-102, May 17, 1978)

"Better Coordination Could Improve Provision of Federal Health Care in Hawaii" (HRD-78-99, May 22, 1978)

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

"Federal Hospitals Could Improve Certain Cancer Treatment Capability by Sharing" (HRD-79-42, Feb. 7, 1979)

"Military Medicine is in Trouble: Complete Reassessment Needed" (HRD-79-107, Aug. 16, 1979)

"Health Costs Can be Reduced by Millions of Dollars If Federal Agencies Fully Carry Out GAO Recommendations" (HRD-80-6, Nov. 13, 1979)

"Inpatient Care at Quantico Naval Hospital Should Not be Resumed" (HRD-80-26, Nov. 29, 1979) and

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