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STATEMENT OF
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BEFORE THE
SENATE COMMITTEE ON VETERANS' AFFAIRS
ON
[S. 266,
A BILL TO ESTABLISH A FEDERAL INTERAGENCY MEDICAL
RESOURCES COMMITTEE]
AND
THE NEED FOR LEGISLATION TO ENABLE VA TO FULLY
COOPERATE WITH DOD IN PLANNING FOR THE CARE
OF RETURNING WARTIME CASUALTIES

Mr. Chairman and members of the Committee, we are pleased to be here today to discuss two recently introduced legislative proposals to encourage the Department of Defense (DOD) and the Veterans Administration (VA) to cooperate more fully in providing health care to Federal beneficiaries both during peacetime and in the event of war. S. 266 would establish a Federal Interagency Medical Resources Committee to ensure, through increased sharing, the most efficient and effective use of Federal direct health care resources during peacetime. The other proposal, included in H.R. 3502, recognizes the need for VA and DOD to participate in joint contingency planning and raises the priority of members of the Armed Forces for treatment in VA hospitals during war or national emergency.

We support congressional passage of S. 266 and agree with authorizing VA to fully participate with DOD in planning for the treatment of returning battlefield casualties.

S. 266

In our opinion, S. 266 constitutes a much needed legislative statement of policy and guidance to the two largest direct health care systems--DOD and VA--to more efficiently spend the billions of dollars appropriated annually to them for operating, constructing, and equipping health care facilities. Legislation, such as S. 266, and DOD's and VA's effective implementation of it, should also, in our opinion, result in the establishment of a sound foundation for increased cooperation between the two agencies in planning and caring for returning wartime casualties as envisioned in H.R. 3502.

S. 266 addresses the obstacles to interagency sharing of medical resources identified in our June 1978 report "Legislation Needed to Encourage Better Use of Federal Medical Resources and Remove Obstacles to Interagency Sharing" (HRD-78-54, June 14, 1978). I would like to submit a copy of that report for the record.

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

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

--Reducing the Government's growing reliance on health delivery programs, such as DOD's CHAMPUS and VA's CHAMPVA, which provide care not available from the Federal direct health care providers.

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

Also, beneficiaries, in some cases, could be treated in Federal facilities closer to their residences and save money because they would not be required to pay portions of the cost of care. Legislation, such as that proposed in S. 266, is very much needed to take advantage of sharing opportunities in a way which will be mutually beneficial to the Government and its beneficiaries.

Background

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 costs without adversely affecting the quality of care provided to Federal beneficiaries.

This issue should be particularly important to DOD and VA officials because of their responsibilities for providing most direct health care to eligible Federal beneficiaries. Together, DOD and VA spent about $10.6 billion in fiscal year 1980 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 responsibilities without considering the needs and capabilities of other Federal agencies. However, in early 1978, a unified position on interagency sharing was taken by high-level representatives of the Government's major direct health care systems. The principal medical officials from DOD, VA, and the Department of Health and Human Services (HHS) agreed that one approach to providing the highest possible quality of care with the greatest efficiency was to accept common goals and to share resources.

The Federal Health Resources Sharing Committee was established in 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.

To accomplish its goals and objectives, the Sharing Committee used several legislative authorities which permit Federal interagency sharing. In our opinion, however, 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.

As part of its operating procedures, the Sharing Committee 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. Subcommittees include those for cardiac catherization laboratories, computerized tomography scanners, cancer treatment facilities, and medical information systems.

In January 1980, the Chairman of the Sharing Committee approved the establishment of a legislation subcommittee. Its purpose was to give the Sharing Committee a review of the existing obstacles to resource sharing along with recommended actions for removing these barriers where possible. The subcommittee's work was used in developing S. 2958 (a bill similar to S. 266), which was passed by the Senate last year but not acted on by the House.

GAO Reports Support the Need for Increased Interagency Sharing of Medical Resources

We have invested considerable resources since 1975 in dealing with the issue of Federal health care resources sharing. The sharing of medical resources--particularly the more specialized and expensive ones--has the potential for significant budget savings to the Government and the taxpayer. Appendix I to our statement lists the GAO reports which address opportunities for interagency sharing of Federal medical resources. Many of these reports pertain to matters ultimately considered by the Sharing Committee in attempting to implement an effective sharing program. The Sharing Committee and its subcommittees have met regularly over the past 3-1/2 years and involved many medical and administrative support personnel from DOD, VA, and HHS. Nevertheless, these efforts have not, in our opinion, resulted in much substantive progress in implementing effective Federal interagency sharing arrangements. This is not to say, however, that no sharing is taking place between individual health care facilities in the Federal sector. Also, the Committee's efforts are continuing. For example, the Committee is considering establishing a permanent staff to focus on the process of identifying and promoting opportunities for joint planning and use of Federal medical resources.

Current sharing arrangements are being accomplished in the absence of a legislatively established environment which specifically encourages sharing. S. 266 would establish such an environment which should pave the way for substantially increased sharing of Federal medical resources.

Obstacles to Sharing

Our June 1978 report identified the basic reasons for the lack of substantive progress in taking advantage of the sharing opportunities as:

--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.

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

We believe that attempts to share, whether initiated at the Federal hospital level or by an interagency group such as the Sharing Committee, are hindered by the same obstacles.

We concluded that the Federal Government has a unique opportunity to take the lead in medical resources sharing. Taking full advantage of this opportunity, however, requires action by the Congress and a concerted effort by the involved agencies to eliminate obstacles to sharing and establish a more efficient Federal health care delivery system. We strongly believe that the legislative and administrative obstacles to sharing could be eliminated without adversely affecting the level or quality of care given to the agencies' primary beneficiaries.

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

We recommended, therefore, that the Congress enact legislation to specifically overcome the obstacles to sharing which we had identified.

GAO Supports S. 266

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 increasing concern about the spiraling costs of health care. This legislation would also provide the impetus and direction DOD and VA need to make interagency sharing more a rule than an exception. S. 266 addresses the factors we believe are essential to implementing an effective medical resources sharing program.

For example:

--Section 2(a)(5) recognizes the importance of both VA's and DOD's current responsibilities and, therefore, reaffirms their respective missions. This is important to the agencies, and we

believe their implementation of this legislation would enhance their ability to seek and obtain alternative sources of care for their beneficiaries while controlling rising health care costs.

--Section 2(b) states that the bill's purpose is to clarify and expand the authority of VA and DOD as direct health care providers to facilitate 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 (e.g., administrative, laboratory, and laundry) needed by Federal direct health care providers.

--Section 3(2) appropriately defines "beneficiary" as any individual entitled by law to direct health care furnished by either VA or DOD. However, the Acting Administrator of Veterans Affairs, in commenting on this bill, stated that neither VA's facilities nor its mission was designed to furnish health care services to military dependents. He suggested that "* * * it should be clear that the type of resources to be shared, and the class of beneficiary to be treated, is best left to the discretion of the treating agency so as to avoid conflict with the primary mission of that agency." (Underscoring supplied.)

Based on extensive work in this area, we believe that the exclusion of any specific category of beneficiaries from potential sharing arrangements would be too limiting and ill-advised. In

this regard, we noted several instances where VA facilities were providing health care services to military dependents without detrimental effects on VA's primary beneficiaries. Services which VA facilities have the potential to provide to military dependents are wide-ranging and include nuclear medicine, radiation therapy, computed tomography scans, and laboratory services. These services do not necessarily require provision of inpatient hospital care.

We believe that S. 266 contains an appropriate definition of whom could be served under interagency sharing agreements, particularly in view of the direction in the bill (section 4(a)(7)(D)) that sharing will be accomplished on a referral basis which will not adversly affect the quality of care and priority of access for medical services of the providing agency's beneficiaries.

--Section 3(5) defines "negotiated cost" 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" or "full" 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 "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 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 even no cost. In any case, if the reimbursements are mutually agreeable to both parties, sharing will take place.

Also, as provided in section 4(a)(7)(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, and including it in the bill should overcome one of the major obstacles to sharing we identified.

--Section 4(a) of the bill establishes a Federal Interagency Medical Resources Committee.

In our recommendation to the Congress for implementing an effective Federal medical resources sharing program, we recommended that responsibilities similar to those contained in section 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, has preferred to rely on its budget examiners and other staff already working with the affected agencies.

S. 266 clearly delineates congressional policy on the issue of sharing medical resources and specifies that the Federal Interagency Medical Resources Committee's primary responsibility is to fully and effectively implement this congressional policy. The formal congressional recognition of the Committee as being responsible for implementing the provisions of S. 266 and reporting to the Congress on the progress of its implementation satisfies the intent of our report recommendation.

--Section 4(a)(6) requires the Committee to consult with other agencies which provide health care directly to Federal beneficiaries to encourage optimum delivery of such care. Although DOD and VA represent most of the Federal Government's direct health care resources and are responsible for providing health care to the largest segments of the Federal beneficiary population, other Federal agencies, including HHS, also provide care to specified categories of beneficiaries. Many of these persons have current or future eligibility for care in military and/or VA facilities (for example, commissioned Public Health Service and Coast Guard personnel). Although we originally recommended including HHS representation on the Committee, we believe this section along with section 4(b) should give DOD and VA the necessary latitude to coordinate their health care activities with these agencies when it is in their beneficiaries' and the Federal Government's interest to do so.

--Section 4(a)(7)(G) provides that sharing arrangements become operative when the facilities' directors or commanding officers agree to share, unless disapproved by the agencies' headquarters. We reported that VA Central Office procedures for reviewing and approving proposed formal sharing agreements submitted by local VA hospital officials were unnecessarily complex and time-consuming. The VA Acting Administrator, in commenting on this provision, stated that VA has made considerable progress in streamlining the sharing agreements' review process and did not believe this provision was needed.

We believe that formal approvals of individual sharing agreements by VA's Central Office before sharing is initiated at the local level is not necessary and could, as in the past, cause delay. VA's streamlined review process should permit timely review to assure that locally initiated sharing arrangements are in the best interests of VA and the Government without requiring Central Office approval before sharing begins.

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In summary, we believe the Federal Government has the opportunity to promote substantially increased sharing of its health care resources and achieve corresponding savings while maintaining, or even enhancing, the access to and quality of care provided to their beneficiaries. In our opinion, the enactment of S. 266 would represent a significant step in that direction.

NEED FOR LEGISLATION TO ENABLE VA TO FULLY COOPERATE WITH DOD IN PLANNING FOR THE CARE OF RETURNING WARTIME CASUALTIES

Legislative changes to VA's mission and responsibilities are needed for VA to fully participate in the planning for the care of returning battlefield casualties. H.R. 3502, which was approved in May 1981 by the House Committee on Veterans' Affairs, would formally establish VA's health care system as the primary backup to DOD's health care system for treating U.S. military personnel during war or national emergency. The bill would establish a special priority for treating active duty military members during war or national emergency which would be second only to the priority of service-connected veterans for care in VA facilities.

The need for legislation which accomplishes these objectives was pointed out in our June 1980 report, "The Congress Should Mandate Formation of a Military-VA-Civilian Contingency Hospital System" (HRD-80-76). I would also like to submit a copy of this report for the record.

In this report, we expressed concern about DOD's development of a civilian-military contingency hospital system under which DOD augments its medical capability by making pre-arrangements with civilian sector hospitals for the treatment of returning casualties during a war or national emergency. Our principal concern focused on the fact that the extent to which VA could support DOD in treating such casualties had not been determined.

DOD's plan envisions VA caring only for casualties not expected to return to duty. However, VA's longstanding mission has been to care for such veterans, and such a plan involves no real change in VA's responsibilities. VA should be much more involved in planning and caring for all returning battlefield casualties, not just those not returning to duty.

We believe the Congress should, as H.R. 3502 does, add the responsibility of caring for casualties expected to return to duty to VA's current mission, so that DOD and VA can take advantage of the time now available in peacetime to develop plans using available Federal medical resources to care for battlefield casualties. The alternative--waiting until a national emergency occurs before fully involving VA--could, in our opinion, result in

--unnecessary confusion during mobilization regarding where returning casualties should be sent for medical care,

--underuse of VA's medical capabilities during war or conflict,

--inability of DOD to know what the total Federal wartime medical capability is to identify the shortage which needs to be made up by the civilian sector, and

--unnecessary effort and expense by DOD to identify and contract for civilian medical resources.

In our opinion, the Nation should prepare for a possible conflict by planning to fully use Federal medical resources before calling on non-Federal resources. We believe that a contingency hospital system which uses VA's medical resources for all categories of returning casualties, including those expected to

return to active duty, would be an efficient and effective use of Federal medical capabilities. Moreover, we believe that a strong peacetime medical resources sharing program, such as that provided for in S. 266, should result in the establishment of a sound foundation for effective working relationships between VA and DOD, which could be invaluable in the event of war.

This concludes my statement, Mr. Chairman. 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, Apr. 7, 1976)

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

"Many Cardiac Catheterization Laboratories Underused in Veterans Administration Hospitals: Better Planning and Control 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)

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

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