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Health Care

Resource Sharing Between
DoD and the Department
of Veterans Affairs
(D-2003-063)

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Acronyms

CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CMAC	CHAMPUS Maximum Allowable Charge
GAO	General Accounting Office
MHS	Military Health System
MTF	Military Treatment Facility
NMCP	Naval Medical Center Portsmouth
PMA	President's Management Agenda
PTF	President's Task Force
VA	Department of Veterans Affairs
VAMC	VA Medical Center
WAMC	Womack Army Medical Center



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March 14, 2003

MEMORANDUM FOR ASSISTANT SECRETARY OF DEFENSE
(HEALTH AFFAIRS)

SUBJECT: Report on Resource Sharing Between DoD and the Department of Veterans
Affairs (Report No. D-2003-063)

We are providing this report for your information and use. No written response to this report was required, and none was received. Therefore, we are publishing this report in final form.

We appreciate the courtesies extended to the staff. For additional information on this report, please contact Mr. Michael A. Joseph at (757) 872-4698 or Mr. Sanford W. Tomlin at (757) 872-4716. See Appendix D for the report distribution. The team members are listed inside the back cover.

David K. Steensma
Deputy Assistant Inspector General
for Auditing

Office of the Inspector General of the Department of Defense

Report No. D-2003-063

March 14, 2003

(Project No. D2002LF-0129)

Resource Sharing Between DoD and the Department of Veterans Affairs

Executive Summary

Who Should Read This Report and Why? DoD medical program managers involved in developing and evaluating medical resource sharing initiatives between DoD and the Department of Veterans Affairs (VA) should read this report. Understanding barriers to sharing and the numerous initiatives to address those barriers will help management coordinate an overall strategy and increase the sharing that occurs between DoD and VA.

Background. DoD and VA operate two of the nation's largest health care systems with a combined budget of \$45.7 billion in FY 2002. The primary mission of the DoD Military Health System is to provide health support for the full range of military operations and sustain the health of all those entitled to DoD health care. The primary mission of the Veterans Healthcare System is to serve the needs of America's veterans by providing primary care, specialized care, and related medical and social support services. To improve the cost-effectiveness of Federal health care, while benefiting beneficiaries of DoD and VA, Congress passed legislation in 1982 to encourage resource sharing. A variety of organizations have performed audits and reviews to determine barriers to sharing. Additionally, DoD and VA have established a Joint Executive Council to provide senior-level oversight of resource sharing efforts.

Results. Although DoD and VA have made progress, barriers exist to increased local sharing. Numerous audits and reviews have identified and reported many barriers to local sharing between the two Departments. Removal of the barriers would facilitate local sharing agreements and ensure health care resources are more fully used. In addition to local sharing agreements, DoD and VA have ongoing departmental-level oversight and initiatives to increase sharing. Increased sharing is also part of the focus of recent executive actions and legislation.

Because of ongoing efforts of numerous groups to review resource sharing between DoD and VA, we limited our review to summarizing reported barriers to local sharing agreements and the status of departmental-level sharing efforts. We did not evaluate management controls.

Management Comments. We provided a draft of the report on January 6, 2003. No written response to this report was required, and none was received. Therefore, we are publishing this report in final form.

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Background

Health Care Systems. DoD and the Department of Veterans Affairs (VA) operate two of the largest health care systems in the United States. The primary mission of the DoD Military Health System (MHS) is to provide health support for the full range of military operations and sustain the health of all those entitled to DoD health care. The primary mission of the Veterans Healthcare System is to serve the needs of America's veterans by providing primary care, specialized care, and related medical and social support services.

In FY 2002, the MHS included 8.4 million eligible beneficiaries, 131,000 staff, 76 hospitals, and 460 ambulatory clinics with a budget of approximately \$24 billion.¹ In FY 2002, the Veterans Healthcare System included about 25.3 million eligible beneficiaries, 202,000 staff, 163 medical centers, 850 ambulatory care and community-based clinics, 137 nursing homes, 43 domiciliary facilities, 73 comprehensive home-care programs, and 206 readjustment counseling centers with a budget of approximately \$21.7 billion.

President's Management Agenda. The President's Management Agenda (PMA) for FY 2002 consists of five Government-wide and nine agency-specific initiatives for improving Federal Government management. The administration envisions improved performance through the removal of barriers to efficient management. Coordination of DoD and VA programs and systems is one of the nine agency-specific initiatives. The PMA states that, although DoD and VA have different missions, there is mission overlap, which presents opportunities for cooperation between the health care systems. The PMA outlines four areas of opportunity for achieving improvements in DoD/VA sharing:

- improving data sharing between DoD and VA health care systems;
- improving the VA health care enrollment database, possibly by using the Defense Enrollment Eligibility Reporting System;
- eliminating dual eligibility of military retirees for care under DoD and the VA health care systems by requiring annual enrollment in one system or the other, and
- implementing recommendations of the President's Task Force.

The President's Task Force to Improve Health Care Delivery for Our Nation's Veterans was established to improve health care coordination between DoD and VA. Executive Order No. 13214 established the President's Task Force (PTF) in May 2001.

The PMA states implementation of the areas of opportunity will result in a seamless transition from active duty to veteran status, greater accuracy in

¹ The MHS budget for FY 2002 included a one-time amount of \$3.9 billion for the TRICARE For Life Trust Fund.

forecasting patient population and budget requirements for both Departments, improved patient continuity of care with the patient using only one health care system, and increased sharing of health care services between DoD and VA.

Legislation Authorizing DoD/VA Sharing. Congress passed specific legislation to encourage resource sharing in order to improve the cost-effectiveness of Federal health care by reducing redundancy and underuse of resources, while benefiting beneficiaries of DoD and VA. Federal agencies have had the authority to share health care resources since the passage of The Economy Act (section 1535, title 31, United States Code) in 1932. Additionally, the Veterans Administration and Department of Defense Health Resources and Emergency Operations Act of 1982 authorized DoD and VA health care facilities to enter into local agreements to share health care on a reimbursable basis. The shared resources could include hospital and ambulatory care, dental services and appliances, health care support and administrative services, medical equipment, and facilities. Title II of the Veterans Health Care Act of 1992 authorized VA medical centers (VAMCs) to provide care to DoD beneficiaries as a TRICARE network provider. The Act requires that, “care to DoD beneficiaries must result in the improvement of services to eligible veterans at the facility.” In addition, care provided to DoD beneficiaries at VA facilities should not result in the denial or delay in access to care for any veteran.

The National Defense Authorization Act for FY 2003 contains provisions to increase sharing between DoD and VA and overcome barriers to sharing. One provision is the establishment of the Joint Incentives Program that requires the Secretaries of DoD and VA to identify and implement “creative” coordination and sharing initiatives. Another provision establishes the Health Care Resources Sharing and Coordination Project. The project is designed to test the feasibility and quality of initiatives designed to improve sharing.

VA/DoD Executive Councils. Identifying and removing the barriers to sharing is the focus of three high-level councils composed of executives from each Department. The Joint Executive Council is composed of senior-level executives. The Benefits Executive Council and the Health Executive Council report to the Joint Executive Council.

Audits and Reviews. A variety of organizations have performed audits and reviews to determine barriers to sharing between DoD and VA. Summaries of General Accounting Office (GAO) reports addressing barriers to sharing are in Appendix B. Summaries of reviews performed by other organizations from 1996 through 2001 that also address barriers to sharing are in Appendix C.

Types of Coordination and Sharing. DoD and VA have developed several types of sharing. Sharing between DoD and VA falls into four major categories: local sharing agreements, joint ventures, national sharing initiatives,² and remote delivery of health services. Local sharing agreements are between DoD and VA facilities in close proximity and may cover major medical, surgical, laundry, and administration and support services. Joint ventures occur when DoD and VA

² For the purpose of this review, we included regional sharing initiatives with national initiatives.

share in the construction or operation of hospitals. Joint ventures seek to avoid costs by pooling resources to build new facilities or capitalize on existing facilities. Joint ventures are operating in Anchorage, Alaska; El Paso, Texas; Fairfield, California; Honolulu, Hawaii; Key West, Florida; and Las Vegas, Nevada. National sharing initiatives identify and implement interagency initiatives that are national in scope, such as consolidated purchasing, patient safety, and development of common information systems. National sharing initiatives also include the treatment of personnel suffering from traumatic brain injury or injury to the spinal cord. Remote delivery of health services are agreements between the Military Departments and VA designed to provide health services support to beneficiaries of the MHS in remote areas. DoD defines remote areas as those areas that are more than 50 miles from the nearest military treatment facility (MTF).

Objectives

The objective of the audit was to review the process used by DoD and VA for sharing resources and the effectiveness of existing resource sharing initiatives. Because of ongoing efforts of numerous groups to review DoD and VA resource sharing, we limited our audit to summarizing reported barriers to local sharing agreements and the status of departmental-level sharing efforts. We did not evaluate management controls. See Appendix A for a discussion of the scope and methodology and Appendixes A, B, and C for prior coverage.

Status of DoD/VA Sharing

Although DoD and VA have made progress, barriers exist to increased local sharing. Numerous audits and reviews of DoD/VA sharing have identified barriers to local sharing including:

- variations in access standards,
- incompatible information systems,
- inconsistent charging and reimbursement policies,
- potential legal conflict with TRICARE contracts,
- lack of capacity, and
- few incentives for sharing.

Removal of the barriers would facilitate DoD/VA local sharing agreements and ensure health care resources are more fully used. In addition to local sharing agreements, DoD and VA have ongoing departmental-level oversight and initiatives to increase sharing. Increased sharing is also part of the focus of recent executive actions and legislation.

Local Sharing Agreements

DoD does not maintain data on the value and number of DoD/VA sharing agreements. In September 2000, DoD contracted with Eagle Group International, Inc., to obtain comprehensive data on sharing agreements and barriers to sharing. The Eagle Group issued “Independent Assessment of Department of Veterans Affairs and Department of Defense Sharing Agreements and Program,” December 31, 2001 (Eagle Report). The Eagle Group surveyed all VA health care facilities and reported that 639 active sharing agreements were in place between the DoD and VA health care systems during FY 2000. However, only 406 of the agreements were used, resulting in reimbursements of about \$56 million.

Barriers to Local Sharing

The following paragraphs discuss the major barriers to local sharing agreements disclosed in prior audits and reviews along with the results of our visits to DoD and VA facilities in Hampton Roads, Virginia, and Fayetteville, North Carolina.

Variations in Access Standards. Variations in access standards hinder sharing. DoD implemented Department-wide standards for TRICARE Prime³ enrollee access; however, implementation of VA Department-wide standards for access is not required until FY 2006. The VA access standards do not include timeframes for acute care or routine care appointments, while DoD access standards require acute care and routine care appointments be scheduled within 24 hours and 7 days, respectively, of request. According to the Eagle Report, many VA personnel expressed frustration that their facility did not meet DoD standards and that their system did not offer similar access to veterans. DoD access standards must be followed by all health care organizations entering into agreements to provide care for TRICARE Prime enrollees. For VA to be a DoD provider, VA has to meet DoD access standards. Doing so, in effect, could give TRICARE Prime enrollees priority over veterans for appointments when VA access standards are less timely than DoD access standards.

The PTF interim report, issued in July 2002 (see summary in Appendix C), stated that timely access to VA health care is hampered because enrolled veterans' demand for VA health care services is greater than the amount of funding VA receives to respond to that demand. Based on the PTF interim report and briefings, it appears much attention is focused on the variation between DoD and VA access standards and the PTF final report will address access standards as a barrier.

Information Systems. Resource sharing between DoD and VA is hindered because financial and medical information cannot be easily shared due to incompatible information systems. Compatible financial information systems would improve decisions based on financial data and compatible medical information systems would reduce the risk of medical errors when beneficiaries of one system are treated in the other system.

According to a Senate study dated July 30, 1998 (see summary in Appendix C), facility leaders within both Departments generally agree that their financial information systems do not provide reliable, accurate, or useful estimates of costs for specific services. Without accurate cost estimates, the Departments cannot make good decisions on whether to purchase care from the private sector or share the providing of medical services. The Senate study indicates the development of accurate cost estimates is hindered by the complexity of cost accounting systems and the multiple sources and accounting methods for tracking costs related to equipment, facility, and support services. Accurate cost determination within DoD is further hindered by the competing demands on the MHS to provide peacetime health services as well as satisfy wartime requirements and readiness and training missions. The Senate study concludes that one of the keys to realizing the potential of local sharing opportunities will be accurate cost accounting and appropriate pricing of services.

DoD and VA also maintain and use incompatible medical information systems. In order to maximize sharing opportunities, the Departments must be able to

³ TRICARE consists of three options: Prime, Extra, and Standard. TRICARE Prime is equivalent to a civilian health maintenance organization.

exchange compatible and comparable clinical data. GAO reported (see summary of GAO Report No. GAO-02-1017 in Appendix B) that DoD and VA patients who receive medications from both Departments face an increased risk of medication errors, in part because information in one Department's medical information system is generally not accessible by the other Department.

The National Defense Authorization Act for FY 2003 requires the establishment of a DoD/VA Health Care Resources Sharing and Coordination Project at a minimum of three sites. At the selected sites, coordinated financial and medical information systems must be developed to identify departmental costs and to effectively communicate medical information.

Charging and Reimbursement Policies. In the past, charges for services provided under resource sharing agreements varied significantly because there was no consistent methodology for computing costs or setting prices. The Eagle Report stated DoD and VA personnel used a wide range of methods to determine charges for services rendered under sharing agreements. The rates were ad hoc agreements between DoD and VA facilities and were highly dependent on the staff negotiating the sharing agreement. Some agreements had no clear description of the basis for the rates and some based their rates on CHAMPUS⁴ maximum allowable charge (CMAC), Medicare rates, interagency rates, cost-plus-markup, incremental cost incurred, or bartering.

On May 3, 2002, the Under Secretary of Defense for Personnel and Readiness and the VA Deputy Secretary issued a statement that a single financial reimbursement methodology would be used for determining charges and reimbursements between the two Departments. The financial reimbursement methodology agreed to was the CMAC less 10 percent. The rate would be applied to both institutional and professional charges. However, waivers from using the standardized rate could be granted if the standardized rate did not cover marginal costs or if the standardized rate was higher than local market rates and both parties desired a larger reduction from CMAC.

Initial implementation of the standardized rate for ambulatory care services started the first quarter of FY 2003. Implementation for inpatient care was planned to begin in the third quarter of FY 2003. The Health Executive Council expects that using a standard reimbursement rate will simplify negotiations on sharing agreements, standardize business practices, enhance data analysis, and simplify billing between DoD and VA.

Potential Legal Conflict With TRICARE Contracts. Some DoD and VA facilities closely located may not have established sharing agreements because of the potential legal conflict with TRICARE contracts. According to GAO, in early 1999, the TRICARE Assistant General Counsel issued an opinion that sharing agreements between DoD and VA violated the managed care support contracts in Regions 1, 2, and 5.⁵ The opinion was based on a clause in the TRICARE

⁴ Civilian Health and Medical Program of the Uniformed Services.

⁵ Those regions were impacted because they operated under a revised financing version of the TRICARE contract.

contracts for those regions that stated MTFs could not establish separate networks for non-primary care outside of the TRICARE network. On May 14, 1999, the Assistant Secretary of Defense (Health Affairs) issued a memorandum to the TRICARE lead agents through the Surgeons General that stated DoD policy was to encourage VA health facilities to participate in the TRICARE network as providers. The memorandum appeared to restrict DoD to referring patients in those regions to VAMCs that were TRICARE network providers, in effect prohibiting MTFs from using existing sharing agreements with VA.

Discussions with VA personnel disclosed that the VA would prefer to provide services through local sharing agreements rather than through the TRICARE network. Additionally, receiving VA services through sharing agreements would also allow DoD to avoid paying the TRICARE contractor profit and overhead costs.

On August 1, 2002, the DoD TRICARE Management Activity released the TRICARE Contract Request for Proposal for the next generation of TRICARE contracts. The Request for Proposal allows DoD and VA to enter into direct sharing agreements for mutually agreed upon services. Bids for the TRICARE Contract Request for Proposal were due January 29, 2003.

Capacity. The potential to establish local sharing agreements may be limited due to the lack of available capacity in DoD and VA health care facilities. According to the Eagle Report, it appears there is little available capacity in DoD for sharing health care services and available VA capacity is limited to inpatient care.

Capacity is discussed throughout the Eagle Report, which states that the DoD capacity to treat VA beneficiaries is not known but, due to significant downsizing of DoD personnel and facilities, there may not be available capacity for DoD to treat VA beneficiaries. The report states that VA facilities have available inpatient capacity, but not outpatient capacity. The report further states that the best opportunities for sharing might not be in health care services, but in infrastructure, national purchasing programs, integrated facilities, common information systems, and common logistical efforts.

The National Defense Authorization Act for FY 2003 states that at least one of the three sites in the Health Care Resources Sharing and Coordination Project will include a coordinated DoD and VA personnel and staffing assignment system. The establishment of a coordinated personnel and staffing system is an important step toward ensuring any unused capacity within each Department at a given location is identified and shared on a day-to-day basis.

Incentives. According to the PTF interim report, neither DoD nor VA provides sufficient incentives to encourage health care facility senior management to enter into local sharing agreements. Additionally, the Senate study stated that facility leaders in both systems focus on coping with requirements to serve their own beneficiary populations as their first priority. Sharing opportunities may be lost because only one Department will benefit. Therefore, sharing agreements are essentially limited to those situations in which both Departments will benefit. “The Report to the Vice President on Strategies for Jointly Improving VA and DoD Health Systems,” May 1996 (see summary in Appendix C), states DoD and

VA agreed the best strategy for sharing would be to link the two health care networks wherever there is substantial mutual benefit. Following are two examples of recently proposed sharing agreements at sites we visited that demonstrate sharing agreements are typically limited to situations in which both Departments benefit.

Fayetteville. In a September 2001 proposal, Fayetteville VAMC requested that Womack Army Medical Center (WAMC) bid on VAMC surgeons performing 50 general surgeries annually at WAMC. The proposal stated Fayetteville VAMC would provide a surgeon to WAMC 1 day a week and, after performing surgery on a VA patient, the surgeon would be available for the rest of the day to perform surgeries on WAMC patients. WAMC would be responsible for providing the operating room and support staff. Although WAMC had the available operating room space, WAMC rejected the Fayetteville VAMC surgery proposal because WAMC did not have available inpatient capacity that some surgery patients would need during recovery. WAMC also stated that the VA surgeon would need to be available more than 1 day a week to perform the pre- and post-operative care associated with surgery.

MTF commanding officers are evaluated on how well they care for TRICARE Prime enrollees and not how well they care for VA beneficiaries. Caring for VA patients in areas where the MTF has a heavy workload could affect access for TRICARE Prime enrollees or force the MTF to send those enrollees to contract providers, which would increase MTF operating costs. In addition, the WAMC commanding officer stated there are no guarantees that DoD and VA will continue to provide the staffing needed to support sharing agreements negotiated at the local level.

Hampton Roads. A visit to Hampton VAMC and Naval Medical Center Portsmouth (NMCP) showed local sharing agreements for health care services can be worked out when both Departments benefit. For example, in May 2002 Hampton VAMC submitted a sharing agreement proposal to NMCP requesting NMCP to perform approximately 300 general inpatient surgeries for the VA annually. NMCP agreed and began performing the surgeries in July 2002. As of January 27, 2003, the reimbursement rate for the surgeries was still being negotiated. NMCP agreed to perform the surgeries because it needed to increase the number of specific types of surgeries to maintain its accreditation for Graduate Medical Education programs.

The PTF interim report states that neither DoD nor VA consistently provided incentives for leadership to foster DoD/VA collaborative efforts. The co-chair of the PTF told Congress that the instances where DoD and VA treatment facilities have forged joint operating and sharing agreements occurred because local leaders in those communities made them a priority. According to the co-chair, there are not many incentives to encourage DoD and VA to cooperate and pursue sharing opportunities. The promotion system in the military does not lend itself to include incentives or rewards for sharing and VA does not have an explicit structure that rewards sharing. The co-chair stated that people will perform to what they are being measured against and having performance incentives will drive change. We agree that incentives for sharing and measures of program success are essential to maximize sharing opportunities.

Departmental-Level Oversight and Initiatives

In addition to the local sharing agreements, oversight and coordination is ongoing at the DoD and VA departmental level to identify and implement joint sharing opportunities. Departmental sharing opportunities are implemented primarily through national sharing initiatives and have significant mutual benefit potential because the focus is on major information systems, procurements, and infrastructure common to DoD and VA health care systems.

Joint Executive Council. The Joint Executive Council was established in January 2002 and is co-chaired by the Under Secretary of Defense for Personnel and Readiness and the VA Deputy Secretary. The Joint Executive Council includes senior DoD and VA health care managers involved in sharing initiatives. Responsibilities of the council include providing direction for ongoing sharing initiatives and discussing measures to further increase collaborative efforts. Quarterly meetings are held to provide leadership oversight of interdepartmental cooperation at all levels and to oversee the efforts of the Health Executive Council and the Benefits Executive Council. In May 2002, the Joint Executive Council chartered the VA/DoD Joint Strategic Planning Executive Steering Committee to develop a joint 5-year strategic plan for DoD/VA collaboration.

Health Executive Council. The co-chairs of the Health Executive Council are the Assistant Secretary of Defense (Health Affairs) and the VA Under Secretary for Health. The council includes senior-level health executives from both Departments and the Military Surgeons General. The Health Executive Council works to improve local sharing as well as national sharing and is responsible for developing departmental-level initiatives that will result in increased sharing between DoD and VA. To satisfy that responsibility, the Health Executive Council has established the following nine workgroups: Benefits Coordination, Geriatric Care, Financial Management, Information Management/Technology, Joint Facility Utilization/Resource Sharing, Patient Safety, Clinical Practice Guidelines, Pharmacy, Medical Surgical Supplies, and Deployment Health. The workgroups are composed of field and headquarters personnel with expertise in the specific area and are charged with identifying areas where increased DoD/VA coordination can be realized.

Benefits Executive Council. The Benefits Executive Council is co-chaired by the Principal Deputy Under Secretary of Defense for Personnel and Readiness (formerly the Assistant Secretary of Defense [Force Management Policy]) and the VA Under Secretary for Benefits. The Benefits Executive Council provides an official forum for senior-level interaction between the DoD and the Veterans Benefits Administration. The council is examining ways to expand and improve information sharing, refining the process of record retrieval, and identifying procedures to improve the benefits claims process.

Infrastructure. DoD and VA are collaborating in their respective capital asset planning initiatives. The DoD workgroup for health care facilities planning includes personnel from each Military Department's medical facility planning office and VA representatives. In the fall of 2002 the VA selected a nine-member commission to implement a program called Capital Asset Realignment for

Enhanced Services that supports the improved delivery of health care services. At the request of the VA Under Secretary of Health, DoD provided the VA with three personnel to assist in the planning process for the program. The three DoD personnel provide expertise in the clinical, facilities, and operations areas of health care. The DoD TRICARE lead agents attend VA regional meetings to provide information on the capabilities of the local MTFs. The commission will analyze demographics and services at VA clinics and hospitals and issue a report in August 2003 with recommendations on where to add or eliminate services to improve efficiency. The VA/DoD Joint Strategic Planning Executive Steering Committee will provide oversight of the VA Capital Asset Realignment for Enhanced Services and the DoD Base Realignment and Closure processes.

Consolidated Purchasing. DoD and VA have been able to achieve savings by entering into joint contracts to purchase pharmaceuticals. According to the Joint Executive Council, as of December 2001, there were 57 joint national contracts, 35 pending joint contracts, and 30 proposed joint contracts. By consolidating purchases, the Departments are able to exert leverage to obtain discounts when they commit to buy increased volumes of drugs. According to GAO, the joint procurement discounts resulted in a cost avoidance of about \$40 million in FY 2000. According to the VA Deputy Secretary, joint procurement discounts for pharmaceuticals totaled about \$98 million in FY 2001.

GAO testified in June 2002 that potential savings exist if DoD and VA purchase medical and surgical supplies jointly. Although DoD and VA achieved modest savings by purchasing medical and surgical supplies through local joint contracting agreements, the Departments had not awarded joint national contracts. Although it is difficult to quantify the potential savings that joint national contracts could yield, GAO stated the savings could be meaningful, given that the Departments' separate national and regional contracts are expected to save an estimated \$19 million annually.

Common Information Systems. The Health Executive Council developed the Joint VA-DoD Electronic Health Records Interoperability Plan. The plan is intended to result in computerized health record systems that ensure interoperability between the DoD and VA health information systems. To achieve the objective to have interoperable computerized health record systems, the Departments intend to standardize health and related data, communications, security, and software applications where appropriate. GAO testified in September 2002 that DoD and VA anticipate being able to implement a two-way exchange of health care information by the end of 2005. Currently, the Departments are using the Federal Health Information Exchange to share health care information. The Federal Health Information Exchange allows a one-way transfer of data from existing DoD health care information systems to a separate database that VA hospitals can access. According to GAO, information provided through the Federal Health Information Exchange has been particularly valuable to VA for treating emergency room and first-time patients.

Patient Safety Program. DoD established its patient safety program by adopting the patient safety program developed by VA. The cornerstone of the program is the centralized collection and analysis of patient safety data. VA is developing software for maintaining a database of reported adverse events that cause, or could

cause, unexpected harm to a patient while providing care. DoD is considering using the VA software, once it is completed, to keep program development cost at a minimum and facilitate the sharing and consolidation of patient safety data. VA also developed a training program for patient safety personnel at each of its hospitals, and DoD developed training that parallels the VA program. The training ensures consistency in the methods for identifying and researching adverse events. The Health Executive Council provides oversight to this national sharing initiative.

Executive and Legislative Focus

Increased sharing is the focus of recent executive and legislative actions. The PTF to Improve Health Care Delivery for Our Nation's Veterans was established to improve health care coordination between DoD and VA. In addition, a detailed approach to increase sharing is included in the National Defense Authorization Act for FY 2003.

President's Task Force to Improve Health Care Delivery for Our Nation's Veterans. The PTF was tasked to identify opportunities for improved resource use through DoD/VA partnership; review barriers impeding DoD/VA coordination; and identify opportunities to improve business practices to ensure high quality and cost-effective care. The PTF tasking also included the identification of ways to improve benefits and services for VA beneficiaries and DoD military retirees eligible for VA benefits through better coordination between the two Departments.

To accomplish the President's tasking, the PTF established workgroups to review benefit services, acquisition and procurement, facilities, information management/information technology, leadership and productivity, pharmaceuticals, and resource/budgeting. The workgroups were directed to identify opportunities for sharing and make recommendations for improvements. The PTF issued an interim report in July 2002 discussing the progress made in each of the areas reviewed by the workgroups. The interim report did not make any recommendations; however, the report concluded that DoD and VA lack the required coordinated resource planning and budgeting process to ensure collaboration. In addition, both Departments have independent performance measures, which do not provide incentives for appropriate interdepartmental collaboration.

The PTF recognizes that there are numerous reasons for the history of limited collaboration between DoD and VA, including differing missions, funding limitations, incompatible information systems, and institutional cultural barriers. The PTF is attempting to address those barriers and a final report is due March 30, 2003. The final report is expected to have recommendations that will address barriers, encourage all types of sharing where appropriate, and have a measurable impact on the delivery of benefits and services.

National Defense Authorization Act for FY 2003. The National Defense Authorization Act for FY 2003 requires the establishment of a Joint Incentives Program and a Health Care Resources Sharing and Coordination Project. The Joint Incentives Program will require that the Secretaries of DoD and VA identify and implement “creative” coordination and sharing initiatives. The initiatives may occur at local, regional, or national levels. To fund the Joint Incentives Program, each Secretary is expected to contribute at least \$15 million from appropriated funds on an annual basis, beginning October 1, 2003. The program will terminate on September 30, 2007. The program’s implementation and effectiveness is to be reviewed annually by the Comptroller General. The review is to include an analysis of the funds expended on sharing initiatives, an analysis of any improvements in the quality of care received by beneficiaries, and recommendations about possible legislative improvements to the program.

The Health Care Resources Sharing and Coordination Project is to be carried out at a minimum of three sites where the feasibility and quality of initiatives designed to improve sharing can be evaluated. The sites selected should have at least one VA facility and one MTF in close proximity. All of the sites will test at least one element of a coordinated management system with at least one site testing all elements.

The coordinated management system elements include:

- a budget and financial management system that will provide managers with costing information that will enable them to assess the cost-effectiveness of using either Department for health care;
- a staffing and assignment system for personnel; and
- a medical information and information technology system that is compatible with the project’s purposes.

Funds for the Health Care Resources Sharing and Coordination Project are to be made available by each Secretary beginning in FY 2003. The funding amount from each Department is \$3 million in FY 2003, increasing to \$9 million in FY 2005, and remaining at that amount until the project terminates in September 2007. The Comptroller General is to conduct annual on-site reviews at each location and submit a report to the Senate and House Committees on Armed Services and Veterans’ Affairs. The report is to include a statement that the funds appropriated for sharing activities are being used for direct support of the sharing initiatives.

In addition, the National Defense Authorization Act for FY 2003 has provisions that require the Secretaries of both Departments to develop a joint strategic vision statement and strategic plan to help in shaping and coordinating the sharing effort. The Act establishes the interagency VA-DoD Health Executive Committee to provide strategic direction for sharing efforts and to oversee the implementation of those efforts. We believe that developing a joint strategic plan and creating an interagency committee to provide strategic direction as required in the National Defense Authorization Act for FY 2003 will facilitate the removal of barriers to DoD and VA sharing.

Summary

Removing identified barriers will provide opportunities for increased DoD/VA sharing at the facility level. However, we agree with the Eagle Report that significant opportunities for sharing are in national sharing initiatives such as infrastructure, information systems, logistics, and the establishment of totally integrated facilities. The coordinated Department-level focus being provided by the Joint Executive Council, the PTF, and provisions of the National Defense Authorization Act for FY 2003 provides the proper forum to address the major opportunities for sharing. Although limited progress has been made with sharing initiatives, it is critical that recent momentum be maintained. Establishing a strategic vision and plan with measures of success will facilitate sharing at all levels. Because of the summary nature of this report, we are not making recommendations.

Appendix A. Scope and Methodology

We reviewed the DoD and VA Health Resources Sharing and Emergency Operations Act of 1982; applicable Assistant Secretary of Defense (Health Affairs) and VA guidance; and relevant statutes to obtain policies and procedures that address DoD/VA resource sharing and to obtain criteria that must be met in order to enter into agreements. We reviewed pertinent congressional legislation addressing DoD/VA sharing. We reviewed the section of the PMA for FY 2002 pertaining to DoD/VA sharing. We reviewed Executive Order No. 13214 establishing the PTF on DoD/VA sharing. We reviewed previous audits and studies of DoD/VA sharing carried out since 1996.

We interviewed a DoD member and a VA member of the Health Executive Council to discuss issues the council is addressing. We interviewed members of the PTF, to include DoD and VA subject matter experts on resource sharing, leadership, and productivity, and the head of the resource/budgeting workgroup. We interviewed the VA representative to TRICARE contract negotiations to determine VA concerns regarding DoD/VA sharing under TRICARE. We interviewed personnel assigned to the Assistant Secretary of Defense (Health Affairs) to obtain a history of DoD/VA sharing, the status of local sharing agreements, studies of DoD/VA sharing, and the status of strategic planning between the two Departments. We attended PTF sessions to discuss and gain insight into the functioning of the task force and actions the task force is contemplating. We attended the TRICARE Region 2 conference session on resource sharing to obtain an overview of the interaction of VA and TRICARE.

We met with personnel from Hampton VAMC, Richmond VAMC, Fayetteville VAMC, NMCP, and WAMC to determine the status of local sharing agreements and how sharing opportunities are identified. At those locations, we also discussed departmental barriers and site-specific barriers to DoD/VA sharing.

We performed this audit from April 2002 through January 2003 in accordance with generally accepted government auditing standards.

The scope of our review was limited. Because numerous groups are reviewing DoD/VA sharing, we limited our review to summarizing reported barriers to local sharing agreements and the status of departmental-level sharing efforts. We did not evaluate management controls. In addition, we relied on reports, studies, and testimonies provided by other groups without validating the information.

Use of Computer-Processed Data. We did not rely on any computer-processed data.

GAO High-Risk Area. The GAO has identified several high-risk areas in DoD. This report provides coverage of the DoD Infrastructure Management high-risk area.

Prior Coverage

During the last 5 years, the Inspector General of the Department of Defense (IG DoD) issued one report discussing DoD/VA sharing. Unrestricted IG DoD reports can be accessed at <http://www.dodig.osd.mil/audit/reports>. Summaries of DoD/VA sharing reviews by GAO are in Appendix B and reviews performed by other organizations are in Appendix C.

IG DoD

IG DoD Report No. D-2001-037, "Collection and Reporting of Patient Safety Data Within the Military Health System," January 29, 2001

Appendix B. General Accounting Office Reviews

Following are summaries of reports issued by GAO addressing DoD/VA sharing issues during the past 5 years. Unrestricted GAO reports can be accessed over the Internet at <http://www.gao.gov>.

GAO Testimony No. GAO-02-1054T, “VA Information Technology: Management Making Important Progress in Addressing Key Challenges,” September 26, 2002. The testimony was given before the House Subcommittee on Oversight and Investigations, Committee on Veterans’ Affairs. GAO gave an update on the progress of the DoD, VA, and Indian Health Service Government Computer-Based Patient Record Project. The Government Computer-Based Patient Record Project was originally envisioned as establishing an electronic interface that would enable DoD, VA, and the Indian Health Service to share patient information among their health information systems by creating a “virtual record” that could be viewed on the provider’s or authorized user’s computer monitor. The project was scaled back and renamed the Federal Health Information Exchange Program. The Federal Health Information Exchange Program is now a joint project between DoD and VA that enables the exchange of health care information between DoD and VA. The Federal Health Information Exchange Program is a one-way transfer of information from the DoD health care information system to a separate database that VAMCs can access to obtain demographic and limited clinical information on Service members who have separated from the military. The Federal Health Information Exchange Program is available at all VAMCs and is showing good results.

GAO Report No. GAO-02-1017, “VA and Defense Health Care: Increased Risk of Medication Errors for Shared Patients,” September 2002. Congress requested that GAO perform an audit of how effective medication safeguards were for patients shared between the DoD and VA health care systems. GAO found increased risk in medication safety occurred due to separate, uncoordinated information systems and formularies maintained by DoD and VA. The gaps were attributed to the inability of providers and pharmacists to access complete patient records in the other Department’s system. The report recommended developing the capability for providers to access relevant patient information, regardless of which information system the information resided on, and providing training for providers on how to access the information. GAO further stated there were risks to patients when providers used the other Department’s formulary because the formulary may contain drugs unfamiliar to providers. The report recommended the establishment of a joint DoD/VA pharmacy and therapeutics committee or workgroup to determine the best way to meet the medication needs of shared patients.

GAO Testimony No. GAO-02-969T, “VA and DoD Health Care: Factors Contributing to Reduced Pharmacy Costs and Continuing Challenges,” July 22, 2002. The testimony was given before the House Subcommittee on National Security, Veterans Affairs, and International Relations, Committee on Government Reform. GAO discussed how DoD and VA had reduced pharmacy costs by establishing formularies, a variety of pharmaceutical purchasing arrangements, and Consolidated Mail Outpatient Pharmacies. The report stated that the Departments need to address how differences in their patient populations, national formularies, and prescribing practice patterns among providers can be managed to assist with further joint procurement of pharmaceuticals.

GAO Testimony No. GAO-02-872T, “VA and Defense Health Care: Potential Exists for Savings through Joint Purchasing of Medical and Surgical Supplies,” June 26, 2002. Congress requested that GAO perform an audit of DoD and VA progress in joint procurement of medical and surgical supplies. GAO stated that DoD and VA had saved more than \$170 million annually by jointly procuring pharmaceuticals. However, the Departments had not been successful in developing a joint national contract for medical and surgical supplies due to differing approaches to contracting and the inability to identify similar high-volume, high-dollar items purchased by each Department. The testimony disclosed both Departments were implementing automated procurement information systems but the data provided by the new systems may not be compatible.

GAO Report No. GAO-01-459, “Computer-Based Patient Records: Better Planning and Oversight by VA, DoD, and IHS Would Enhance Health Data Sharing,” April 2001. In 1998, DoD, VA, and Indian Health Service initiated the development of the Government Computer-Based Patient Record. The purpose of the Government Computer-Based Patient Record was to create an electronic interface enabling DoD, VA, and the Indian Health Service to share patient data. Due to the complexity of the Government Computer-Based Patient Record, Congress subsequently asked GAO to report on the project’s timeframes, costs, and expected benefits and determine if barriers to the project’s progress existed. GAO reported the basic principles of information technology planning, development, and oversight were not being followed. The report recommended the creation of comprehensive coordinated plans to include agreed-upon goals, mission statement, objectives, and performance measures so that the Departments can share patient health care data. The report also recommended the designation of a lead agency with final decision-making authority and the establishment of a clear line of authority.

GAO Report No. HEHS-00-52, “VA and Defense Health Care: Evolving Health Care Systems Require Rethinking of Resource Sharing Strategies,” May 17, 2000. Congress requested that GAO study DoD/VA health care resource sharing, concentrating on the benefits gained from sharing resources, the extent of sharing between the Departments, and barriers encountered in attempts to share. GAO reported that there were significant long-standing barriers to sharing and that sharing occurred between very few DoD and VA facilities. The barriers cited in the report were inconsistent reimbursement and budgeting policies; an apparent lack of understanding regarding the setting of reimbursement rates (incremental verses total costs); budgeting processes that encourage local facilities to keep

beneficiaries within their own health care systems; lack of available capacity in the VA facilities; and a DoD legal opinion that prohibited MTFs from using local sharing agreements. The report recommended that DoD contractors be given guidance on how to process VA claims and ensure timely reimbursement and that VA facilities follow VA guidelines to charge incremental costs. The report also recommended that DoD and VA perform an assessment to determine the most cost-effective means of providing care to beneficiaries, along with the current and future available capacity, and that DoD reevaluate its sharing position and determine the most cost-effective way to use Federal health care resources. The report further recommended that Congress should consider providing direction if DoD and VA could not resolve differences on resource sharing.

Appendix C. Other Reviews of DoD/VA Sharing

“President’s Task Force to Improve Health Care Delivery for Our Nation’s Veterans, Interim Report,” July 31, 2002. The PTF interim report identifies the following critical issues that must be addressed in order to increase DoD and VA sharing.

- The mismatch between funding for the VA health care system and the demand for services from VA enrollees must be resolved.
- Senior DoD and VA leadership must be continuously committed to encouraging DoD and VA sharing.
- DoD and VA must manage the rapidly escalating costs of pharmaceuticals.
- DoD and VA must recognize the role of information management and information technology in supporting sharing efforts and use those tools.

In addition, the interim report states that recommendations from previous studies of DoD/VA sharing had not been aggressively or effectively implemented. Policies and decisions made at the senior level had not consistently been carried out at the local or regional level. The report states that recommendations had not been implemented because implementation and leadership responsibilities had not been well defined; guidance, strategic plans, and goals to direct the operational levels of DoD and VA in the sharing effort were needed; and performance measures to monitor progress had not been instituted. The PTF plans to include recommendations in its final report, expected to be issued in March 2003, that will eliminate barriers and promote sharing to ensure veterans receive high-quality care in a timely fashion.

“Independent Assessment of Department of Veterans Affairs and Department of Defense Sharing Agreements and Program,” December 31, 2001 (Eagle Report). The Eagle Group International, Inc., under DoD contract, conducted a study of DoD/VA sharing. The Eagle Group developed an inventory of sharing agreements, reviewed sharing policy, and determined the use of each sharing agreement. The Eagle Report states that many of the facilities involved in resource sharing agreements had no idea of the costs, revenues, or value derived from the sharing agreements. It also states that a study was needed to determine whether it would be more beneficial for the Government to pursue direct sharing of resources between DoD and VA or to have VA become a TRICARE network provider.

The report also noted a lack of guidance and training. Specifically, VA personnel cited a lack of training about the sharing program and the function of VA as a TRICARE provider, and DoD personnel cited the management of the sharing program. Both DoD and VA personnel said the process of negotiating agreements was lengthy and cumbersome. The report recommended simplifying the sharing

program through the issuance of policy encouraging regional and national agreements when possible. It also recommended that DoD and VA simplify the sharing agreement approval process and establish timeliness standards for the local-level approval process.

The Eagle Report cites lack of a clear reimbursement methodology as a barrier. Other barriers discussed in the report include no available capacity to allow participation in a sharing program, the inability of the VA to meet DoD access standards, the lack of a strategic plan for the development and use of sharing agreements, and incompatible medical and cost accounting systems. The report further states that the best opportunities for sharing might not be in health care services, but in infrastructure, national purchasing programs, integrated facilities, common information systems, and common logistical efforts.

“A Joint Review of Law and Policy for DoD/VA Sharing,” March 15, 1999 (Birch and Davis). Birch and Davis Associates, Inc., were hired by DoD to conduct a review, mandated by Public Law 105-261, of law and policies to identify barriers to sharing between DoD and VA. The review found that, generally, there were no barriers within the laws that provide legislative and policy guidance for sharing. However, the review identified several non-legislative barriers to sharing. For example, it found that a common perception of MTF and VA officials was that resources saved through sharing were not benefiting the facility. Also, the review found information technology incompatibilities between the DoD and VA computerized medical information systems and cost accounting systems. The review found that no study had been performed to determine whether it would be more beneficial to pursue direct sharing of resources between DoD and VA or to have VA facilities become TRICARE providers, and the report recommended that a feasibility study be conducted. The report concludes that due to base closures, downsizing of DoD personnel and facilities, and demand by TRICARE beneficiaries exceeding available services, it appears that DoD capacity is limited.

“Congressional Commission on Servicemembers and Veterans Transition Assistance,” January 14, 1999 (Principi Report). Congress, through the Veterans’ Benefits Improvement Act of 1996, established the Commission on Servicemembers and Veterans Transition Assistance. The Commission was tasked with reviewing programs that provide benefits and services to veterans and Service members transitioning to civilian life and proposing recommendations as needed. The Principi Report recommended the Departments combine their purchasing power to negotiate lower prices and further reduce costs by eliminating redundant procurement operations. The report also recommended joint procurement of information technology and the development of a cost accounting system with the capability of generating financial and management data to enhance partnering by overcoming institutional barriers.

“The DoD and VA Health Systems: Increased Access and Improved Cost Effectiveness Through Enhanced Partnering,” July 30, 1998 (Senate Study). The report from the Senate Committee on Armed Services that accompanied the National Defense Authorization Act for Fiscal Year 1998 requested that the Secretary of Defense conduct a study, in conjunction with the VA, to explore DoD/VA partnering actions. The study was to focus on actions that could be

implemented to improve beneficiary access to health care while also improving the overall cost-effectiveness of both health care systems. The study noted that a barrier to sharing was a shortage of primary care resources by both DoD and VA. Another reported barrier was that VA facilities had organizational and financial incentives to share, but MTFs appeared to have no such incentives. The study further noted that the lack of a reliable cost accounting system, and the resulting inability to arrive at acceptable prices, limited the volume of services obtained through sharing agreements.

“Report to the Vice President on Strategies for Jointly Improving VA and DoD Health Systems,” May 1996 (DoD and VA). As part of the Reinventing Government initiative, DoD and VA were tasked to establish a long-range vision of DoD and VA health care systems. DoD and VA were also tasked with performing a joint study to determine effective incentives to encourage maximum cooperation, sharing, and integration at the local levels. The report, issued jointly by DoD and VA, recommended the creation of a Sharing Alliance Planning Board to enhance joint planning. Goals for the Board included developing strategic plans to enhance efficient health care delivery, identifying opportunities for the sharing and integration of services to maximize use of resources, and facilitating the implementation of sharing initiatives.

Appendix D. Report Distribution

Office of the Secretary of Defense

Under Secretary of Defense (Comptroller)/Chief Financial Officer
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Deputy Comptroller (Program/Budget)
Under Secretary of Defense for Personnel and Readiness
Principal Deputy Under Secretary of Defense for Personnel and Readiness
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Department of the Navy

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Senate Committee on Governmental Affairs
Senate Committee on Veterans' Affairs
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House Committee on Armed Services
House Committee on Government Reform
House Subcommittee on Government Efficiency, Financial Management, and Intergovernmental Relations, Committee on Government Reform
House Subcommittee on National Security, Veterans Affairs, and International Relations, Committee on Government Reform
House Subcommittee on Technology and Procurement Policy, Committee on Government Reform
House Committee on Veterans' Affairs

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