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STAFF REPORT TO THE COMMITTEE ON VETERANS' AFFAIRS

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DEPARTMENT OF VETERANS AFFAIRS AND DEPARTMENT OF DEFENSE HEALTH RESOURCES SHARING

STAFF REPORT TO THE COMMITTEE ON VETERANS' AFFFAIRS

Purpose.—This staff report to the Chairman and Ranking Member of the Veterans' Affairs Committee is intended to analyze the current status of health resources sharing between facilities of the Department of Veterans Affairs (VA) and Department of Defense (DoD). The law authorizing sharing was enacted in order to make better use of such facilities and to improve access to quality health care for beneficiaries of both departments. This report also discusses new opportunities for enhancing sharing authority and recommends legislation to achieve more VA-DoD resource sharing.

BACKGROUND

Veterans Administration and Department of Defense Health Resources Sharing and Emergency Operations Act.—In 1982, Congress enacted the Veterans Administration and Department of Defense Health Resources Sharing and Emergency Operations Act, Public Law 97–174, 38 U.S.C. 8111, (the Sharing Act) to foster more effective sharing of health care resources between the former Veterans Administration, now the Department of Veterans Affairs, and the Department of Defense. Previously, VA and DoD health care facilities, many of which are co-located or in close geographic proximity, operated virtually independently of each other. This occurred despite opportunities to enhance access and quality of service for beneficiaries, and save funds through shared clinical care and joint procurement. The intent of the law was not only to remove legal barriers, but also to provide incentives for military and VA health care facilities to engage in sharing through local agreements, joint ventures, national sharing initiatives, and other collaborative efforts to more effectively and efficiently use Federal health resources.

The Sharing Act gives local health care executives flexibility in establishing sharing agreements, including conducting negotiations, developing reimbursement methods and bartering services, as well as streamlining the review and approval processes to minimize bureaucratic delay from Washington. As an incentive to share, it provides that a facility furnishing services retain funds earned from such sharing. To encourage establishment of sharing as an important priority, the Sharing Act requires the VA's Under Secretary for Health and DoD's Assistant Secretary for Health Affairs to recognize health resources sharing as an ongoing respon-

sibility. The Sharing Act has been amended three times in response to proposals by the departments to improve the relationship between them. Currently, a Presidential Task Force to Improve Health Care Delivery for our Nation's Veterans is reviewing VA and DoD policies and practices relating to sharing to identify new or potential opportunities and make recommendations to the VA and Congress to promote increased sharing.

The VA-DoD annual report to Congress in January 2000 depicted sharing as a robust program with "virtually all" VA and DoD facilities involved. In reality, however, while VA and DoD have increased sharing in sheer dollar volume and added many new agreements over the past twenty years, the total amount of sharing remains miniscule as a percentage of the two departments' combined health care outlays. According to VA's Office of Medical Sharing, in fiscal year 2001 VA and DoD shared services valued at only $58 million out of the two departments' total health care budgets of approximately $35 billion—about two-tenths of one percent of their medical spending.

Congressional Commission on Servicemembers and Veterans Transition Assistance.—The difficulties in VA-DoD sharing are already a matter of record. The January 1999 Report of the Congressional Commission on Servicemembers and Veterans Transition Assistance questioned whether the two departmental health care systems could survive as separate entities unless they continued to receive funding supplements, or restructured and realigned with each other. To improve their prospects the Commission recommended:

- Joint procurement of pharmaceuticals, medical and surgical supplies, and medical equipment.
- Interoperable clinical, management and financial information systems.
- Joint procurement of health information technology.
- Development of compatible cost accounting systems and a joint resource allocation and budgeting process.
- Combined funding of graduate medical education.
- Recognition of VA medical centers as equivalent to military treatment facilities in DoD's TRICARE community health program for military retirees and dependents.
- Combined policy staff and process to review health facilities construction requirements.

The Commission reported that it was imperative for the departments to enter into a "true partnership" and restructure their organizations to overcome cultural and institutional barriers that needlessly separate them.

There are over 400 active health care sharing agreements and eight joint ventures between VA and DoD involving 150 facilities. However, about 75 percent of the $62 million in sharing currently reported is derived from agreements at only 30 sites.

Inpatient Care.—About 75 percent of shared inpatient care (defined as acute bed care of more than 24 hours in duration) is provided at only 12 locations: Madigan Army Medical Center, Ft. Lewis, WA; 5th Medical Group, Minot AFB, ND; 319th Medical

Group, Grand Forks AFB, ND; Ralph H. Johnson VA Medical Center, Charleston, SC; Walter Reed Army Medical Center, Washington, DC; Brooke Army Medical Center, Ft. Sam Houston, TX; 375th Medical Group, Scott AFB, IL; Oklahoma City VA Medical Center, Oklahoma City, OK; Overton Brooks VA Medical Center, Shreveport, LA; John L. McClellan Memorial Veterans Hospital, Little Rock, AR; Bassett Army Community Hospital, Fort Wainwright, AK; and James A. Haley Veterans Hospital, Tampa, FL.

Ancillary Services.—Most shared ancillary care (defined primarily as nuclear medicine, radiology and laboratory services) is provided at 12 sites: VA Pittsburgh Health Care System, Pittsburgh, PA; Tomah VA Medical Center, Tomah, WI; Walter Reed Army Medical Center, Washington, DC; Arnold Air Force Station, Tullahoma, TN; 5th Medical Group, Minot AFB, ND; Sam Rayburn Memorial Veterans' Center, Bonham, TX; Dayton VA Medical Center, Dayton, OH; Moncrief Army Community Hospital, Fort Jackson, SC; Alvin C. York VA Medical Center, Murfreesboro, TN; Bassett Army Community Hospital, Fort Wainwright, AK; Madigan Army Medical Center, Fort Lewis, WA; and Houston VA Medical Center, Houston, TX.

SITE VISITS

During 2001, Committee on Veterans' Affairs staff conducted fact-finding site visits to VA and military treatment facilities in West Los Angeles and San Diego, CA; Las Vegas, NV; Albuquerque, NM; San Antonio, TX (accompanied by House Committee on Armed Services staff); El Paso, TX; Charleston, SC (accompanied by House Committee on Armed Services staff and staff of Rep. Henry Brown); Fayetteville, NC (accompanied by staff of the General Accounting Office (GAO)); and Chicago, IL (accompanied by GAO and staffs of House Appropriations Subcommittee on VA, HUD and Independent Agencies, Sen. Richard Durbin, Sen. Peter Fitzgerald, and Rep. Mark Kirk).[1]

Los Angeles, CA.—The West Los Angeles VA Medical Center, the VA's largest, is approximately 12 miles from Los Angeles Air Force Base in El Segundo, CA. The Greater Los Angeles VA Healthcare System consists of five ambulatory care centers, eight community based outpatient clinics, the largest medical research program within the VA, and the tertiary care medical center. This VA health care system provides a full spectrum of services to over one million veterans residing in the primary service area. These services include comprehensive medical, surgical, psychiatric, diagnostic, and treatment services, as well as psychiatric specialty programs and comprehensive rehabilitation programs. In addition, the health care system operates a 321-bed domiciliary program and two 120-bed nursing home units.

The fiscal year 2001 budget of the health care system was $384 million. Fiscal year 2001 VA-DoD sharing amounted to only $24,724. Currently, the VA provides limited mental health services to DoD beneficiaries at Los Angeles AFB. The Air Force is building a new outpatient clinic that is expected to open in mid-June 2002.

[1] See Appendix I for site visits and contacts.

There was little evidence of any attempt by the Air Force or the VA to consider a joint venture or partnership arrangement for this facility. Joint staffing issues, reimbursement methodologies and contract negotiations were frequently mentioned as barriers to greater sharing, as well as differences in the beneficiary populations' needs.

San Diego, CA.—The VA San Diego Healthcare System is a major medical, surgical, psychiatric, tertiary, and community care system with a medical center located in La Jolla and community clinics located in Mission Valley, El Centro, Chula Vista, and Vista. It had a fiscal year 2001 budget of $202 million. The medical center, which is a regional center for cardiac surgery and spinal cord injury, has 238 inpatient beds with a 69-bed extended care center and a 30-bed spinal cord injury center. The medical center provides outpatient care through numerous clinics, including the four community clinics named above. This VA health care system also provides ambulatory surgery, rehabilitation, prosthetics, audiology, optometry, and home health care. Specialized programs include PTSD counseling, Agent Orange and Persian Gulf War screening, alcohol and drug treatment programs, and programs for homeless veterans. The health care system collaborates with the University of California at San Diego School of Medicine and operates a large medical research program.

Balboa Naval Medical Center San Diego is a 392-bed tertiary medical center that had a fiscal year 2001 budget of over $388 million. It operates a network of clinics located at area military installations and provides emergency and ambulatory care to the active duty population of all San Diego-based ship and shore commands. The naval medical center also conducts graduate medical education with about 20 different medical disciplines. It is a partner in a sharing agreement with the San Diego VA Healthcare System. Balboa sends its referrals to the TRICARE civilian network, but the VA medical center is not part of the TRICARE network because its management believes it cannot compete with the three civilian medical centers in the area. Balboa is 15 miles from the VA medical center.

Sharing revenue generated between these VA and DoD facilities in the San Diego area was $117,183 for fiscal year 2001. There are graduate medical education agreements among the Navy, the VA and the University of California at San Diego School of Medicine pursuant to which the VA provides resident training for Navy doctors. The VA also provides outpatient and ancillary services for a branch DoD clinic, and the facilities reported that they were finalizing an agreement to share a community clinic that will serve veterans and the military community.

However, both facilities' executives expressed the belief that sharing opportunities are limited because of differences in patient populations. Each facility is large, complex and offers all levels of care with no excess capacity from primary to tertiary care, including complex surgery. Also, the facilities use different financial and clinical data management systems. They reported that frequent rotations of senior Navy personnel created difficulty in maintaining

working relationships and continuity of shared programs, especially in the clinical area.

Las Vegas, NV.—The Mike O'Callaghan Federal Hospital at Nellis AFB outside Las Vegas is a 96-bed Air Force-managed hospital with 52 VA-dedicated beds. The facility opened in 1994. The VA also has a full spectrum outpatient clinic, a stand alone psychiatric day treatment center, two community-based primary care clinics, and a community based outreach center in Las Vegas dedicated solely to the care of homeless veterans. Although this is a unique joint venture of VA and the Air Force's 99th Medical Group, each partner maintains separate budget, financial, human resources and clinical data management systems. The Air Force's budget for fiscal year 2001 was $30 million and the VA's was $16.8 million.

While this facility was planned and built as a "Federal" facility, opportunities to enhance sharing under the Sharing Act have not been explored or have been abandoned. For example, the two separately maintained pharmacies, one for veterans and another for Air Force personnel, retirees and family members, could be consolidated. Also, VA's existing Consolidated Mail Outpatient Pharmacy system could be utilized by DoD beneficiaries in the region; the budgeting, accounting, data and human resources management systems could be combined; management of the separate intensive care units could be merged, along with surgical operating rooms, support facilities and staff; and a common medical record could be established. Such changes would offer dramatic improvements in efficiency and could promote the establishment of new programs that would benefit veteran and military beneficiaries alike.

Albuquerque, NM.—The Albuquerque VA Medical Center and Kirtland AFB Hospital co-location established in 1987 was the inaugural VA-DoD health resources joint venture. There are approximately 186,000 veterans in the area served. In addition to tertiary care, the facility provides primary and secondary care. The facility also provides for the referral of specialty care by the Kirtland AFB clinic to VA physicians. This special partnership offers VA admitting privileges to Air Force physicians. The system currently operates five community based outpatient clinics and has partnered with federally qualified health centers to offer veterans further access to clinics in 13 rural locations throughout the state. The relationships between these facilities have been significantly altered over the duration of their partnership. The original arrangement was that the Air Force operated a separate, 40-bed hospital within the Albuquerque facility. Air Force health command downsizing has resulted in a complete inpatient closure, and the Air Force now purchases all inpatient clinical care services from the VA.

The VA medical center's fiscal year 2001 budget was $186 million, and the Air Force's was $17.6 million. In fiscal year 2001, total sharing revenue was reported to be $6.8 million. While many of the observations of lost opportunities to share observed in Las Vegas do not pertain to Albuquerque, others do. For example, the Air Force and VA needlessly maintain separate dental clinics with separate supply chains and central dental laboratory functions. The Air Force also continues to maintain a management presence as if

it were still operating a separate facility, even though most of its health care services are duplicates of existing VA activities.

San Antonio, TX.—The South Texas Veterans Health Care System is comprised of the Audie L. Murphy, Satellite Clinic, and Kerrville Divisions. The Audie L. Murphy Division is a 294-bed tertiary care facility that provides acute care services to approximately 300,000 veterans in south central Texas. The hospital also contains a 90-bed nursing home unit and a 30-bed spinal cord injury center. The Satellite Clinic Division operates five outpatient clinics in San Antonio, Corpus Christi, Laredo, McAllen, and Victoria. The Kerrville Division provides 25 acute care beds and 154 nursing home care beds. The system is affiliated with the University of Texas Science Center at San Antonio, and supports a Geriatric Research, Education, and Clinical Center.

Brooke Army Medical Center provides primary, secondary, and tertiary care to a large beneficiary pool in Texas, Oklahoma, Louisiana, Colorado, Kansas, Missouri, and Panama. Brooke provides graduate medical education for about 550 students annually. It also provides emergency trauma care to 50 percent of the civilian population in San Antonio and houses the world-renown military Institute of Surgical Research Burn Center. The Army medical center is a new state of the art facility that had a fiscal year 2001 budget of $275.4 million. It has unused bed capacity due to low patient populations. Brook is approximately 17 miles from the VA's Audie L. Murphy Division.

Wilford Hall Medical Center at Lackland AFB is a comprehensive health care system and the Air Force's most important medical center. The facility has 280 beds and is a major referral center. Wilford Hall offers a full spectrum of specialty care and has the Air Force's only trauma center. This medical center has DoD's only allogenic bone marrow transplant center, the U.S. Air Force AIDS/HIV center, and the only stereo lithography in DoD. More than 600 clinical research projects are in progress. Wilford Hall is an older facility that will require major upgrades to maintain its accreditation, plus about $40 million in other needed major maintenance and facility renovations. Its fiscal year 2001 budget was $154 million. The facility is located 11 miles from the VA's Audie L. Murphy Division.

The San Antonio Health Council, which is comprised of the leadership from Wilford Hall, Brooke, VA and the University of Texas Health Sciences Center, is responsible for coordinating healthcare in the San Antonio area, including sharing. The combined medical budgets of the Air Force, Army and VA facilities are over $705 million. The DoD sharing revenue was $679,573.

El Paso, TX.—The VA El Paso Health Care System is a modern ambulatory care center that provides primary and specialized ambulatory services to approximately 74,583 veterans and also operates a community-based outpatient clinic in Las Cruces, NM. The clinic, completed in 1995, is adjacent to the Beaumont Army Medical Center. There is no VA hospital in El Paso, the closest VA hospital being 500 miles away in Albuquerque. Consultants and fee-basis specialists supplement the medical staff. Inpatient care for acute medical and surgical emergencies is provided through a VA-

DoD sharing agreement with William Beaumont Army Medical Center. Services that the VA El Paso Health Care System provide include primary care, urgent care, mental health services, social work, audiology, radiology, ophthalmology, podiatry, orthopedics, laboratory services, pharmacy and surgery. The center has a shared ambulatory surgery suite with eight operating rooms. Affiliation agreements for residency programs in internal medicine and psychiatry are administered through a consortium agreement with Texas Tech University and the Army medical center.

Charleston, SC.—Naval Hospital Charleston, now an outpatient facility, is a 1974-vintage, 350-bed hospital that was downsized as a result of the 1993 Base Realignment and Closure Commission. It now serves as an ambulatory care center providing primary and specialty care for local active duty Navy personnel, family members and retirees. Its fiscal year 2001 budget was $45.1 million. All Navy inpatient care is referred to the TRICARE provider network. Few referrals were made to the Ralph H. Johnson VA Medical Center, which is a designated TRICARE facility located only 6.5 miles away, reportedly because of a lack of capacity at the VA to handle additional inpatient workload.

The Ralph H. Johnson VA Medical Center is a primary, secondary, and tertiary care medical center providing acute medical, surgical, and psychiatric inpatient care, as well as primary and specialized outpatient services. The medical center is affiliated with the Medical University of South Carolina and has one of the leading open-heart surgery programs in the southeastern United States. It also conducts major medical research in diabetes, lipid disorders, heart disease, hematology, fetal alcohol syndrome, kidney disease, and rheumatology. Its fiscal year 2001 budget was $112.5 million. The facility was constructed in 1966 as a 500-bed acute care hospital. It reports an operating capacity of 115 beds, but due to a nursing shortage, only 92 beds are available for patient care admissions.

Both the VA and DoD Charleston facilities are outmoded for delivering health care in a modern and efficient manner. However, the State of South Carolina plans to replace the Medical University of South Carolina's academic health center adjacent to the VA Medical Center. No local plan has been developed, but it is conceivable that the three entities, the Navy, VA and the State of South Carolina, could become a unique example of cooperation in delivering health care by sharing a new multi-purpose federal-state academic health center for the military and civilian residents of eastern South Carolina.

A regional VA Consolidated Mail Outpatient Pharmacy (CMOP), one of eight such facilities nationwide, is located in Charleston and is across the street from the naval hospital compound. It produces 52,000 mailout prescriptions daily for eligible veterans throughout the southeastern United States. The executive staff of the Naval Hospital confirmed an awareness of its existence but had neither visited it nor considered its potential relevance to the naval hospital's pharmacy workload. The Navy reported difficulty recruiting and retaining pharmacy technicians because it could not offer competitive salaries for the Charleston area. Because of pharmacy per-

sonnel shortages, the Navy is experiencing difficulty maintaining its own mailout workload of about 500 daily prescriptions. The CMOP director informed the staff that the facility could easily accommodate an additional 500-prescription daily workload if Navy's requirement could be translated and incorporated into VA's regional automated order-entry network.

Fayetteville, NC.—The Fayetteville VA Medical Center, constructed in 1939, is primarily a long-term care center with a variety of active outpatient programs. The medical center serves 163,205 veterans and operates 157 beds, including a nursing home care unit. It provides acute medical, surgical and psychiatric care, as well as intermediate care. It opened a community-based outpatient clinic in February 1999 in Jacksonville, NC. Through a series of renovation projects, the medical center has a full array of inpatient and outpatient services. The medical center has affiliation agreements with 16 educational institutions covering 24 different areas of study.

Womack Army Hospital is located about 12 miles from the VA medical center. Dedicated March 18, 2000, Womack is the Army's newest medical center. It serves more than 160,000 eligible beneficiaries. The facility has three buildings, including a seven-floor inpatient tower, and exhibits the latest in technology and innovation. Some of the services provided include cardiology, hematology-oncology, pulmonology, and endocrinology. Fayetteville and Womack currently use a magnetic resonance imaging (MRI) unit jointly acquired in 1992. The use agreement will expire in May 2002. However, when the new hospital was built, the Army unilaterally purchased a new MRI unit, disregarding their previous MRI sharing. The result may be increased costs to VA as it sends patients to Womack for magnetic resonance imaging on a fee basis. The VA medical center shares other resources with both the Army hospital and Pope AFB under VA-DoD sharing agreements to augment health care delivery. Pope AFB is 4.8 miles away from Womack Army Hospital.

Womack was planned and built without an institutional laundry on the premise that the VA facility's laundry would accommodate the Army's workload under a sharing agreement. The VA spent $2.9 million to renovate its laundry for that purpose. However, Womack withdrew from this agreement because VA failed to maintain necessary minimal quality. Womack now has a 6-year contract for laundry service with a commercial vendor, and VA's laundry is operating at barely over 50 percent of its intended capacity.

Chicago, IL.—North Chicago VA Medical Center, a member of the VA Great Lakes Health Care System, provides area veterans with primary medical and psychiatric care, medical subspecialty care, ambulatory surgery, and physical medicine, rehabilitation, and supportive ancillary services. Community-based treatment teams provide both home-based primary medical care and psychiatric care for veterans with serious mental illnesses. The VA medical center operates the Evanston Primary Care Clinic adjacent to the Northside Veterans' Center in Evanston and hosts community health clinics throughout northern Illinois. Its primary affiliates are the Finch University of Health Sciences/Chicago Medical

School. The VA medical center also provides clinical experience to Navy corpsmen through a sharing agreement with the Great Lakes Naval Training Center, and it shares the same general military compound in Waukegan with the training center.

Naval Hospital Great Lakes offers a variety of specialty services. Although obstetrical services are not available at the naval hospital, such care is provided through local community hospitals. The naval hospital is part of TRICARE Region 5 under the military's new managed health care plan. The TRICARE Service Center offers benefits counseling, referral processing, enrollment processing and assistance locating providers that accept TRICARE and Medicare. The VA medical center provides the naval hospital with dental and support services and some inpatient, outpatient, and ancillary services. However, neither the Navy's current economic analysis of the naval hospital nor the VA's Capital Asset Realignment for Enhanced Services process addresses an opportunity to enter into a partnership to preserve essential medical infrastructure, promote military readiness and meet the needs of both beneficiary populations.

OBSTACLES TO SHARING

In most site visits, the Committee on Veterans' Affairs staff identified the following systemic obstacles that preclude or discourage VA and DoD facilities from developing or sustaining meaningful sharing arrangements:

- Absence of any statutory requirement for health resources sharing between the departments.
- Inadequate or outdated guidance from the Secretaries of Defense and Veterans Affairs on health resources sharing policy.
- Restrictive regulations, policies and procedures that inhibit health resources sharing.
- Incompatible methods to reimburse costs of services rendered to beneficiaries of the other department's programs.
- Unclear or unstated strategic goals for health resources sharing in either department.
- Absence of sharing goals for regional or facility executives in either department.
- Incompatible computer systems and healthcare workload reporting systems.
- Incompatible information technologies and lack of common information technology goals, resulting in dual entry of workload, duplicative data and wasteful methods of information retrieval.

Senior Management Issues.—Executive leadership is a key to meaningful VA-DoD sharing programs. VA and DoD assign executive personnel in their health care systems according to different internal administrative policies and practices. VA tends to assign its civil service health executives to facilities for long periods, sometimes entrenching poor management practices and promoting empire building. On the other hand, DoD limits military treatment facility commanders (as well as clinical program directors) to much

shorter assignment periods, typically no more than three years. At the change of command or reassignment of the VA medical center executive, agreements between previous executives and commanders may have to be renegotiated or even cancelled.

Health care facility executives of the VA, Army, Navy, Air Force, and Coast Guard are subject to annual performance evaluations. These evaluations focus on matters of policy execution with many common and some unique requirements (for example, readiness in a military treatment facility). The success or failure of a facility's sharing program, however, is rarely evaluated. Executives whose facilities share "too much" with a partner may be perceived as eroding the facility's financial, administrative or clinical foundations to the detriment not only of their facility but also of their careers. Thus, entering into sharing agreements with other federal agencies can be risky behavior, and may be approached cautiously or avoided.

Lack of Funding Incentives.—The Committee on Veterans' Affairs staff observed no positive funding incentives for health care facilities of either department to provide care for each other's eligible beneficiaries when it would be advantageous for the government to do so. In fact, the advent of TRICARE has introduced a powerful disincentive to the referral of military patients to nearby VA facilities. The referring military facility under TRICARE rules must identify a funding source within its allocation to reimburse the VA facility, but no such identification or payment need be made when a military patient is referred to the TRICARE network. Also, Committee staff observed that there are few incentives to jointly procure medical services, devices, supplies or capital equipment, even when the end-use of such goods or services is indistinguishable between the two departments.

Opportunities For Joint Activity

Graduate Medical Education.—Current DoD and VA graduate medical education programs should be reviewed for opportunities for greater collaboration. These opportunities would aid coordination of federal subsidies to the teaching hospitals. Both departments' graduate medical education programs must maintain a sufficient case mix for residency program certifications. Joint DoD and VA residency programs at co-located sites could ameliorate the effects of DoD military deployments. Maintaining competent specialty residency programs is a critical factor in wartime readiness. The Committee on Veterans' Affairs staff believes that DoD programs would benefit from joining VA academic partnerships through exposure to a more diverse clinical mix. Many of the techniques used in VA surgeries and various other invasive procedures are needed for combat-trauma cases.

Joint Procurement.—Despite other examples of joint procurements of magnetic resonance imaging equipment, the recent major capital medical equipment acquisitions by DoD in Fayetteville at Womack Army Medical Center and El Paso at William Beaumont Army Medical Center were made without consultation or coordination with nearby or co-located VA facilities. Such independent decisions affect these facilities' relationships for many years after the

fact, add unnecessary cost, create inefficiency and contribute to further counterproductive decisions in both facilities. These were clearly lost opportunities for joint procurement. In addition to medical equipment, numerous opportunities exist for joint procurement of pharmaceuticals, medical supplies and contracted medical care and support services.

RECOMMENDATION

With the Administration's broad scale defense reviews, reinforced by the terrorist attacks of September 11, 2001, DoD appears to be entering a period of reassessment of its basic military assumptions. This should affect DoD's health policy decisions, as well as facility management and other elements of its health care administration. With its Capital Asset Realignment for Enhanced Services initiative, the VA is also studying the realignment of its health care capital assets. The Committee on Veterans' Affairs staff concludes that as the two departments move ahead, many of the observed organizational barriers and redundancies could be reduced or eliminated, and new incentives could be created to help achieve greater sharing of their health resources.

Demonstration Projects.—The barriers the Committee on Veterans' Affairs, GAO and the Transition Commission identified have reduced the ability of VA and DoD to maximize efficiencies and the quality of patient care that Congress intended for their health care programs. To improve the effectiveness of the existing joint ventures VA and DoD should undertake demonstration projects to:

- Develop and implement integrated and compatible budgets, reimbursement methodologies, cost accounting systems and information technology systems; additionally, develop a budgeting and resource allocation process that takes into account the combined needs of the two departments at each joint venture location, including a demonstration "unified budget," to be presented jointly to Congress by the two Secretaries.
- Create an information infrastructure that facilitates data exchange of patient health, financial and management information across the demonstration sites.
- Consolidate the employment and human resources management authorities of title 10 and title 38 of the U.S. Code; use the new flexibility to develop a hybrid system that incorporates the best of both systems.
- Develop a joint policy staff to identify needs based upon the combined VA-DoD beneficiary population in conjunction with each department's missions; this policy staff should develop a joint strategic plan to accomplish these missions, including identifying opportunities for capital infrastructure projects and joint procurement of equipment, supplies and services.
- Establish a new federal facility in Charleston, SC, that consolidates the Charleston Naval Hospital, the Johnson VA Medical Center and the Medical University of South Carolina academic health center.

- Consolidate VA health care at Womack Army Medical Center, Fayetteville, NC; build a new VA ambulatory and long-term care facility that adjoins Womack.
- Develop a joint patient medical record and combine the Government Computerized Patient Record initiative with VA's Computerized Patient Record System and DoD's Composite Health Care System.
- Develop a "certificate of need"-type requirement for any VA or DoD capital medical acquisition investment or new infrastructure requirements in the 21 co-located VA-DoD facility sites identified by GAO.

Additionally, VA and DoD should mandate a specific savings goal, such as a quantified level of savings over five years based on their combined medical outlays nationwide. The departments should prepare and submit a joint report of such savings achieved through resource sharing initiatives. The departments should also submit an acquisition plan specifying the medical equipment, supplies, clinical services and support services to be jointly procured.

Congress should consider legislation to achieve improved access, readiness enhancement and greater efficiencies in this major health investment by the American people. On July 27, 2001, the Chairman of the Committee on Veterans' Affairs introduced H.R. 2667, the Department of Defense-Department of Veterans Affairs Health Resources Access Improvement Act of 2001.[2]

The bill would:

1. Establish findings of Congress that, after nearly two decades of legislative authority, Department of Veterans Affairs (VA) and Department of Defense (DoD) sharing of health resources is inadequate given the still unfulfilled potential of two independent appropriated Federal health care providers to work together; and the sense of Congress that the departments should explore new ways to improve health resource sharing.
2. Establish a health care facilities integration demonstration project, with five qualifying sites selected jointly by the Secretaries of Veterans Affairs and Defense, to identify advantages and challenges of integrating co-located military and VA health care facilities.
3. Require a unified management system be adopted in the qualified demonstration sites, including budget and financial management; health care staffing and assignment; and, medical information and information technology systems that provide standards of information quality equivalent to those adopted for the departments at large.
4. Empower each Secretary to waive regulations and administrative policies that impede the purposes of the demonstration project with a report of requested waivers and dispositions of requests.
5. Authorize the Secretary of Defense to appoint, using authorities available to the Secretary of Veterans Affairs, under Chapter 74 of Title 38, United States Code, civilian health

[2] See Appendix II for text of bill.

care personnel to duties in facilities unified under the demonstration project.

6. Authorize, to the extent practicable, the same health benefit and co-payment rates for VA and Defense beneficiaries in facilities participating in the demonstration project; prohibit reductions in existing benefit levels or increases in co-payment rates applicable to any patient under care in a unified facility under the demonstration project.
7. Authorize to be appropriated to each department, $10 million for fiscal year 2002 and $25 million for each succeeding year, during the term of the demonstration project, to be used to establish the demonstration project and underwrite further enhancements to VA-DoD sharing.
8. Require the Secretaries of VA and Defense to submit within two years a joint prospectus for construction of a new, more accessible and unified Federal health care facility in an area where co-located VA and DoD facilities need replacement.
9. Require that both Secretaries study, develop, and implement shared affiliation agreements for graduate medical education at demonstration project sites.
10. Require the Secretaries to share health resources when such sharing is feasible and consistent with national policy.
11. Rescind requirement that VA maintain a maximum number of authorized, and a minimum number of operating, hospital and nursing home beds in conjunction with VA-DoD military contingency support.
12. Require Secretaries to submit a final report eight months prior to termination of the demonstration project, and terminate demonstration project on September 30, 2006.

H.R. 2667 will be included in the legislative agenda of the Committee on Veterans' Affairs for consideration during the second session of the 107th Congress.

APPENDIX I

SITE VISITS and CONTACTS

Greater Los Angeles VA Healthcare System, West Los Angeles, CA, February 20, 2001.

Kenneth Clark, Director VA Desert Pacific Healthcare Network
Ronald Norby, Deputy Network Director/Clinical Services Officer VISN 22
Philip P. Thomas, Chief Executive Officer, GLA
Charles Dorman, Chief Operating Officer, GLA
Dr. Dean Norman, Chief of Staff, GLA
Dr. Erika Scremmin, Chief of Physical Medicine/Rehabilitation, GLA
Dr. Phillis Guze, Chief of Medicine, GLA
Dr. Robert Eli, Vice President for Mental Health, GLA
Steve Berman, Chief of Community-Based Services, GLA
Lynn Carrier, Vice President for Administration and Support Services, GLA
Donna Bieter, Vice President for Clinical Support Services and Nurse Executive, GLA
Gloria Martinez, Vice President for Ambulatory and Primary Care, GLA
Dr. Michael Mahler, Vice President for Specialty and Hospital-Based Services, GLA

VA San Diego Healthcare System and *Balboa Naval Medical Center*, San Diego, CA, February 21, 2001.

Ronald Norby, Deputy Network Director, VA Desert Pacific Healthcare Network
Gary Rossio, CEO, VASDHS
Jacqueline G. Parthemore, MD, Chief of Staff, VASDHS
Janet Jones, RN ACOS/Nursing and Patient Care Services, VASDHS
Sarah Simpkins, DDS, VISN 22/DoD Coordinator
Robert Stevens, Administrative Coordinator, External Sites, VASDHS
Cindy Butler, Public Affairs Officer, VASDHS
Capt. Kristine Minnick, Director, TRICARE Southern California, Region 9
Capt. William Roberts, Deputy Commander, Naval Medical Center, San Diego
Capt. Elaine Melissa Kaime, Breast Health Center
Capt. Rick Cole, Nuclear Medicine
Cmdr. Muying Dow, Pharmacy
Douglas Sayers, Public Affairs Officer, Naval Medical Center, San Diego
Dr. Ron Jackson, Civilian Scientist, Defense Spatial Orientation Center

Mike O'Callaghan Federal Hospital, Las Vegas, NV, February 22, 2001.

Ron Norby, Deputy Director, VA Desert Pacific Healthcare Network
John Hempel, CEO, VA Southern Nevada Healthcare System
Sharon Joseph, Acting Chief Operations Officer, VASNHS
Anthony Salem, Chief of Staff, VASNHS
Dan Gerrard, Chief Administrative Officer MOFH
Col. Philip La Kier, 99th Medical Group Commander, CEO MOFH
Col. John Butler, Deputy Commander 99th Medical Group
Col. Stephen Schmidt, Commander, Dental Squadron
Col. Mary Moran, Commander, Medical Operations Squadron
Lt. Col. Evelyn Otero-Ruiz, Operations Officer, Medical Operations Squadron
Lt. Col. Danny Seanger, Commander, Medical Support Squadron
Lt. Col. Verba Moore, Commander, Aerospace Medicine Squadron

New Mexico VA Health Care System and *VA Medical Center–Kirtland AFB*, Albuquerque, NM, February 23, 2001.

Arlene Martin, AF Joint Venture Assistant Director
Smith Jenkins, VISN 18 Director, NMVASCS
Patricia A. McKlem, Interim Chief Executive Officer, NMVAHCS
Barbara K. Chang, M.D., M.A., Chief Medical Officer, NMVAHCS
Ron Richter, Chief, Engineering, Acting Chief Operating Officer, NMVAHCS
Cynthia Nuttall, R.N., Medical Staff Coordinator, NMVAHCS
Catherine Beesley, Joint Venture Director, Management Analyst, CMO, NMVAHCS
Col. Marconi-Dooley, Medical Group Commander
Col. Byers, Medical Group Deputy Commander
Col. Williams, Chief of Professional Services
Maj. Pascoe, Support Squadron Commander

First Naval Hospital and *Ralph H. Johnston, VAMC*, Charleston, SC, April 11, 2001.

Capt. Alana Benton, Commanding Officer
Capt. Ken Meredith, Executive Officer
Robert A. Perreault, Director
Tony Bennett, Chief Financial Officer
Larry Labbate, Physician, Mental Health Service
Patti Snodgrass, Chief Resident, Mental Health Service
T. Lynn McFall, Chief, Physical Medicine and Rehab Service
Philip Freedland, Chief, Radiology Service
Sarah D. Williams, Associate Nurse Executive
Denise R. Carey, Associate Medical Center Director for Patient Care Services
Avtar K. Singh, Chief, Path-Lab Medicine Service
William R. Tyor, Chief, Neurology Service
Bernard G. Williams, Chief, Dental Service
Nancy G. Mikell, Chief, Pharmacy Service

Diane Milligan, Coordinator, Surgical Service
Dexter Hood, Health Administration Officer
Lt. Cmdr. Jeff Plummer, Legislative Liaison–SECNAV

Brooke Army Medical Center, San Antonio, TX, April 17, 2001.

Maj. Gen. Lee P. Rodgers, CG Wilford Hall Medical Center
Brig. Gen. Daniel Perugini, Commander, GPRMC and BAMC
Col. Glenn Taplin, Chief of Staff, GPRMC
Col. Greg Anders, Medical Director, GPRMC
Maj. Tim Edmon, Director of Managed Care, GPRMC
Rosa Wages, Health Systems Specialist, GPRMC
Col. Maryann McAfee, Acting Deputy Commander for Clinical Services, BAMC
Col. Martin Fisher, Deputy Commander for Administration, BAMC
Lt. Col. Carlos Angueira, Dept of Health Plans Management, BAMC
Joe Heer, Management Analyst, BAMC
Col. Thomas Peters, Administrator, WHMC
Col. Philip J. Perucca, Chief of the Medical Staff, WHMC
Lt. Col. Donna Wallace, Plan/Program Analysis, WHMC
Sandra Berrigan, Associate Director for Patient Care, VA
Louise Parker, Assistant to the Chief of Staff, VA

VA El Paso Health Care System and *William Beaumont Army Medical Center*, El Paso, TX, April 18, 2001.

Byron K. Jaqua, CEO, El Paso VA Health Care System
Dr. Stephen Shapiro, Chief Medical Officer, El Paso VA Health Care System
Everett Ray Perdue, Special Assistant to the CEO
Brenda James, Chief Coordinated Care and Social Work Service
Albert Hernandez, Administrative Officer to the CMO
Col. Carla G. Hawley-Bowland, Commander, BAMC
Col. Homer J. Lemar, Acting Deputy Commander for Clinical Services, BAMC
Col. Iris West, Acting Deputy Commander for Patient Services/ Nursing, BAMC
Lt. Col. Leo F. Voepel, Escort Officer, Business Management Division, BAMC
Lt. Col. Al W. Moran, Chief, Business Management Division, BAMC
Maj. Mark C. Wilhite, Acting Chief of Staff, BAMC
Laverne A. Rupkalvis, Business Management Division, BAMC

Fayetteville VA Medical Center and *Womack Army Medical Center*, Fayetteville, NC, May 10–11, 2001.

Daniel Hoffman, Director, VISN 6
Janet Stout, Medical Center Director FVAMC
James Skidmore, Director for Operations FVAMC
Lynn Cooper, RN, Director Patient Care Services FVAMC
Alan Shernoff, DDS, Acting Chief of Staff FVAMC
Joseph Albanese, Chief, Business Office FVAMC
Thomas Hallum, Staff Assistant to the Director FVAMC

Eugene Paul, Minority Veteran/Homeless Coordinator FVAMC
Paul Reid, AFGE Local 2080 President
Norma Byrd, Public Affairs Officer FVAMC
Bonnie Henderson, VBA Regional Office, Winston-Salem
Gerald York, VA Regional Office, Winston-Salem, NC
Col. Matteson, WAMC Commander
Col. Ray Terrill, WAMC Chief of Staff
Lt. Col. Brian Canfield, WAMC Chief Directorate of Business Operations
Lt. Col. John Lee, WAMC Executive Officer
Maj. David Petray, WAMC Chief Resource Management Division
Jan Delaney, WAMC Management Analyst
Chuck Burden, WAMC Chief Clinical Operations Division
Shannon Speight–Lynch, WAMC Public Affairs Officer

North Chicago VA Medical Center, Chicago, IL, June 8, 2001.

Patrick Sullivan, Acting Director
Tariq Hassan, MD, Chief of Staff
Mary Roseborough, MSN, Associate Director for Patient Services/Nurse Executive
Frank Maldonado, MD, Chief of Medicine
Darryl Holst, Leader, Facility Management
Chuck Loring, Facility Management
Terry Martin, Administrative Assistant to the Chief of Staff
Doug Shouse, Staff Asst. to the Director
Kathryn Maginnis, Coordinator for CARES, VAHQ Staff
Jack Hetrick, Deputy VISN Director (at North Chicago VAMC meeting)
Larry Wilson, HSS for VISN 12 (at Great Lakes Naval Hospital meeting)

Naval Hospital Great Lakes, Great Lakes, IL, June 8, 2001.

Capt. Elaine C. Holmes, MC, Commanding Officer
Capt. Raymond J. Swisher, MSC, Executive Officer
Capt. Mathew Ausmus, DC, Director of Surgical Services (Acting)
Capt. Deborah Gray, NC, Director of Nursing Services
Cmdr. Andrea Rosemond, NC, Director of Fleet Medicine (Acting)
Cmdr. Deborah Mathews, NC, Head Quality Assurance (Acting)
Cmdr. Joel Cook, MC, Director of Ancillary Services
Cmdr. Martie Slaughter, MSC, Director for Administration
Lt. Cmdr. Sharon Moser, MSC, Director of Resources Management
Lt. Cmdr. Jennifer Anders, MC, Director of Primary Care (Acting)
Lt. James Stilley, MSC, Head of Managed Care Department (Acting)
Lt. Roland Fahie, MSC, Head of Blood Banking Services Division
Lt. Thomas Matt, MSC, Assistant Director of Resources Management

Lt. Jeff Paul, MSC, Head of Personnel Department
Lt. j.g. Sophie Alexander, MSC, Utilization Review Division
Master Chief Petty Officer Richard Kough, Command Master Chief
Petty Officer 1st Class Sam Collins, Plans/Operations/Medical Intelligence

VA-DoD Resource Sharing Meeting, Washington, D.C., June 27, 2001.

Maj. Gen. Hal Timboe, Medical Corps, Commanding General, North Atlantic Regional Medical Command and Walter Reed Army Medical Center
Rear Adm. K. Martin, Commander, NNMC, Bethesda
Patrick Ryan, Staff Director, HVAC
Art Wu, Deputy Staff Director, HVAC
John Bradley, Staff Director for Health, HVAC
Veronica Crowe, Professional Staff Member, HVAC
Len Sistek, Minority, Oversight and Investigation, HVAC
Susan Edgerton, Minority Staff Director for Health, HVAC
Debra Wada, Minority Professional Staff Member, HASC
Ed Wyatt, Professional Staff Member, HASC
Rebecca Hyder, Legislative Director, Rep. Bilirakis
Art Hamerschlag, Deputy Chief Financial Officer, VHA
Sheila McCready, VHA
Sandy Garfunkel, Director, VAMC, Washington, D.C.
Earl Newsome, VAMC, Washington, D.C.
Edward Demarest, VA–ADOSH
Doug Dembling, VA–OCLA
Ann C. Barr, GAO
Lt. Col. James Grier, Army OCLL
Lt. Cmdr. Jeff Plummer, Navy–OCLL

APPENDIX II

H.R. 2667, DEPARTMENT OF DEFENSE–DEPARTMENT OF VETERANS AFFAIRS HEALTH RESOURCES ACCESS IMPROVEMENT ACT OF 2001

I

107TH CONGRESS
1ST SESSION

H. R. 2667

To provide for a joint Department of Defense and Department of Veterans Affairs demonstration project to identify benefits of integrated management of health care resources of those departments, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JULY 27, 2001

Mr SMITH of New Jersey (for himself, Mr. BILIRAKIS, Mr. EVERETT, Mr. BUYER, Mr. GIBBONS, Mr. SIMMONS, Mr. BROWN of South Carolina, Mr. WAMP, and Mr. KIRK) introduced the following bill, which was referred to the Committee on Veterans' Affairs, and in addition to the Committee on Armed Services, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To provide for a joint Department of Defense and Department of Veterans Affairs demonstration project to identify benefits of integrated management of health care resources of those departments, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Department of Defense-Department of Veterans Affairs Health Resources Access Improvement Act of 2001".

SEC. 2. FINDINGS AND SENSE OF CONGRESS CONCERNING STATUS OF HEALTH RESOURCES SHARING BETWEEN THE DEPARTMENT OF VETERANS AFFAIRS AND THE DEPARTMENT OF DEFENSE.

(a) FINDINGS.—Congress makes the following findings:

(1) Federal health resources provided by the people of the United States through tax receipts are by their nature scarce and thus should be effectively and efficiently used.

(2) In 1982, Congress authorized health resources sharing between Department of Defense medical treatment facilities and Department of Veterans Affairs health care facilities in order to allow more effective and efficient use of their health resources.

(3) Health care beneficiaries of the Departments of Defense and Veterans Affairs, whether active servicemembers, veterans, retirees, or family members of active or retired servicemembers, should

have full access to the health care and services that Congress has authorized for them.

(4) The Secretary of Defense and the Secretary of Veterans Affairs, and the appropriate officials of each of those departments with responsibilities related to health care, have not taken full advantage of the opportunities provided by law to make their respective health resources available to health care beneficiaries of the other department in order to provide improved health care for the whole number of beneficiaries.

(5) After the many years of support and encouragement from Congress, the departments have made little progress in health resource sharing and the intended results of the sharing authority have not been achieved.

(b) SENSE OF CONGRESS.—Congress urges the Secretary of Defense and the Secretary of Veterans Affairs to commit their respective departments to exploring new ways for significantly improving health resources sharing and to building organizational cultures supportive of health resources sharing.

(c) PURPOSE.—It is the purpose of this Act—

(1) to authorize a demonstration program to advance the principles of health resources sharing

consistent with the expressed intent of Congress; and

(2) to establish a basis for joint strategic planning of Department of Defense and Department of Veterans Affairs health systems to ensure that available funds are used more effectively and efficiently in order to enhance access to high quality health care for their beneficiaries.

SEC. 3. HEALTH CARE FACILITIES INTEGRATION DEMONSTRATION PROJECT.

(a) ESTABLISHMENT.—The Secretary of Veterans Affairs and the Secretary of Defense shall conduct a demonstration project to identify advantages of providing for integrated management of military treatment facilities and VA health care facilities that are located in the same geographic area.

(b) SITE IDENTIFICATION.—(1) The Secretaries shall jointly identify five qualifying sites at which to conduct the demonstration project under this section.

(2) For purposes of this section, a qualifying site is an area in the United States in which—

(A) one or more military treatment facilities and one or more VA health care facilities are situated in relative proximity to each other;

(B) for which there could be in effect within one year after the date of the enactment of this Act an integrated budget and personnel system for those facilities; and

(C) as determined by the Secretaries, both the candidate VA facilities and the candidate military medical treatment facilities have in place information systems to demonstrate the validity of the activities of those facilities so that the Secretaries are confident that they will be able to effectively measure differences in activities at those facilities (including cost, access, quality, patient satisfaction, and other important performance indicators) before the demonstration project, during the period of the demonstration project, and after the end of the demonstration project.

(c) CONDUCT OF DEMONSTRATION PROJECT.—At each site at which the demonstration project is conducted, the Secretaries shall provide for a unified management system for the military treatment facilities and VA health care facilities at that site. To the extent feasible, that unified management system shall include—

(1) a unified budget and financial management system for those facilities;

(2) a unified staffing and assignment system for the personnel employed at or assigned to those facilities; and

(3) medical information and information technology systems for those facilities that—

(A) are unified across those facilities;

(B) maintain interoperability with medical information and information technology systems of the respective departments of those facilities; and

(C) incorporate standards of information quality that are at least equivalent to those adopted for the departments at large.

(d) AUTHORITY TO WAIVE CERTAIN ADMINISTRATIVE REGULATIONS AND POLICIES.—(1) In order to carry out subsection (c), the Secretary of Defense may, in the Secretary's discretion, waive any regulation or administrative policy otherwise applicable to the Department of Defense, and the Secretary of Veterans Affairs may, in the Secretary's discretion, waive any regulation or administrative policy otherwise applicable to the Department of Veterans Affairs, as each Secretary determines necessary for the purposes of the demonstration project.

(2) Not later than one year after the date of the enactment of this Act, the Secretary of Veterans Affairs and

the Secretary of Defense shall jointly submit to the Committees on Veterans' Affairs and the Committees on Armed Services of the Senate and House of Representatives a report on the use of the authority provided by paragraph (1). The report shall include a statement of the numbers and types of requests for waivers of regulations and administrative policies that have been made to that date and the disposition of each.

(e) USE OF TITLE 38 PERSONNEL AUTHORITIES.—(1) In order to carry out subsection (c), the Secretary of Defense may apply to civilian personnel of the Department of Defense assigned to or employed at a military treatment facility participating in the demonstration project any of the provisions of subchapters I, III, and IV of chapter 74 of title 38, United States Code, determined appropriate by the Secretary.

(2) For such purposes, any reference in such chapter—

(A) to the "Secretary" or the "Under Secretary for Health" shall be treated as referring to the Secretary of Defense; and

(B) to the "Veterans Health Administration" shall be treated as referring to the Department of Defense.

(f) FACILITIES TO BE DEEMED FACILITIES OF THE OTHER DEPARTMENT.—A VA health care facility participating in the demonstration project shall be considered to be a military treatment facility for purposes of eligibility for care for beneficiaries of the Department of Defense, and a military treatment facility participating in the demonstration project shall be considered to be a VA health care facility for purposes of eligibility for care for beneficiaries of the Department of Veterans Affairs.

(g) BENEFITS, COPAYMENTS, ETC., TO BE EQUALIZED.—In the case of facilities of the participating departments selected to participate in the demonstration project, the medical care for which a beneficiary of the Department of Defense or beneficiary of the Department of Veterans Affairs is eligible, and any required copayments or deductibles for such care applicable to the beneficiaries of either participating department, shall to the extent practicable be the same. Regulations to govern such benefits, copayments, and deductibles shall be prescribed by the Secretary of Defense and the Secretary of Veterans Affairs. However, in no case may the benefits for which any beneficiary is eligible be reduced or any copayment or deductible applicable to any beneficiary be increased.

(h) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to each of the participating departments to carry out the demonstration project—

(1) $10,000,000 for fiscal year 2002; and

(2) $25,000,000 for each succeeding year during which the demonstration project is in effect.

(i) DEFINITIONS.—For purposes of this section:

(1) The term "military treatment facility" means a medical facility under the jurisdiction of the Secretary of a military department.

(2) The term "VA health care facility" means a facility under the jurisdiction of the Veterans Health Administration of the Department of Veterans Affairs.

(3) The term "participating departments" means the Department of Veterans Affairs and the Department of Defense.

(j) TERMINATION.—The demonstration project, and the authority provided by this section, shall terminate on September 30, 2006.

SEC. 4. JOINT PROSPECTUS FOR CONSTRUCTION OF NEW MEDICAL FACILITY.

Not later than two years after the date of the enactment of this Act, the Secretary of Defense and the Secretary of Veterans Affairs shall submit to the appropriate

committees of Congress a prospectus for construction of a new joint medical facility for their respective departments. The location for the new joint facility shall be selected jointly by the two Secretaries and shall be—

(1) at a location where both a current Department of Veterans Affairs medical center and a current Department of Defense military treatment facility are in need of replacement and the new facility can be a replacement for both; or

(B) situated so as to provide improved access to eligible veterans and eligible military beneficiaries in a location where there is only one Department of Veterans Affairs medical center or military medical treatment facility serving one of those beneficiary populations.

SEC. 5. GRADUATE MEDICAL EDUCATION.

(a) FINDINGS.—Congress finds that integration or consolidation of graduate medical education programs of the Department of Defense and Department of Veterans Affairs would—

(1) lead to increased efficiencies by eliminating duplicative administrative processes and streamlining and consolidating joint training programs;

(2) allow increased clinical training sites in Department of Defense and Department of Veterans Affairs accredited programs; and

(3) make Department of Veterans Affairs facilities available to military reserve health care professionals education programs.

(b) COMPREHENSIVE REVIEW.—The Secretary of Defense and the Secretary of Veterans Affairs shall enter into a joint contract for the conduct by an organization outside the Government of an independent, comprehensive review to identify opportunities for joint funding for an integrated graduate medical education program at facilities of their respective departments where such an integrated program is feasible.

(c) FUNDING.—Funds for the contract under subsection (b) shall be provided in equal shares by the Department of Defense and the Department of Veterans Affairs.

(d) COMMON AFFILIATION AGREEMENT.—Based on the results of the review under subsection (b), the Secretary of Defense and the Secretary of Veterans Affairs shall develop and implement a common affiliation agreement or contract for graduate medical education purposes at locations where the demonstration project under section 3 is carried out.

SEC. 6. REQUIRED SHARING OF HEALTH CARE RESOURCES.

(a) REQUIRED SHARING.—Section 8111(a) of title 38, United States Code, is amended by striking "may enter into" and inserting "shall enter into".

(b) CONFORMING AMENDMENT.—Section 1104 of title 10, United States Code, is amended by striking "may" and inserting "shall".

(c) REPEAL OF VA BED LIMITS.—(1) Section 8110(a)(1) of title 38, United States Code, is amended—

(A) in the first sentence, by striking "at not more than 125,000 and not less than 100,000";

(B) in the third sentence, by striking "shall operate and maintain a total of not less than 90,000 hospital beds and nursing home beds and"; and

(C) in the fourth sentence, by striking "to enable the Department to operate and maintain a total of not less than 90,000 hospital and nursing home beds in accordance with this paragraph and".

(2) Section 8111(a) of such title is amended by striking ", except that" and all that follows through "of the Government" before the period at the end.

SEC. 7. REPORTS.

(a) INTERIM REPORT.—Not later than February 1, 2003, the Secretary of Defense and Secretary of Veterans Affairs shall submit to the Committees on Veterans' Affairs and the Committees on Armed Services of the Senate

and House of Representatives a joint interim report on the conduct of programs under this Act through the end of the preceding fiscal year. The Secretaries shall include in the report a description of the measures taken, or planned to be taken, to implement the demonstration project under section 3 and the other provisions of this Act and any cost savings anticipated at facilities participating in the demonstration project.

(b) FINAL REPORT.—Not later than February 1, 2006, the Secretary of Defense and Secretary of Veterans Affairs shall submit to the committees of Congress specified in subsection (a) a joint report on the conduct of programs under this Act through the end of the preceding fiscal year. The Secretaries shall include in the report the following:

(1) A description of activities under this Act.

(2) Identification of cost savings, access improvements, and other efficiencies realized under the demonstration project carried out under section 3.

(3) Analysis of measurable changes achieved by the demonstration project, including the use of data sources and performance indicators described in section 3(b)(2)(C).

(4) Transmittal of the report resulting from the review required by section 5(b), accompanied by ap-

propriate recommendations by the Under Secretary of Veterans Affairs for Health and the Assistant Secretary of Defense for Health Affairs.

(5) Any recommendations of the two Secretaries for expansion of the demonstration project to additional facilities or for modification to any of the authorities for the demonstration project provided in section 3.

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