Assessing CARES and the Future of VA's Health Infrastructure

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STATEMENT OF

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SUBCOMMITTEE ON HEALTH
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

ASSESSING CARES AND THE FUTURE OF VA's HEALTH INFRASTRUCTURE

WASHINGTON, D.C.

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the 2.4 million men and women of the Veterans of Foreign Wars of the U.S. (VFW) and our Auxiliaries, I would like to thank you for the opportunity to testify today.

In April 1999, the Government Accountability Office (GAO) issued a report on the challenges the Department of Veterans Affairs (VA) faced in transforming the health care system. At the time, VA was in the midst of reorganizing and modernizing after passage of the Veterans Health Care Eligibility Reform Act in 1996.

With passage of that bill, VA developed a 5-year plan to update and modernize the system, including the introduction of system-wide managed care principles such as the uniform benefits package. As part of the overall plan, VA increasingly began to rely on outpatient medical care. Technological improvements, improved pharmaceutical options and

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management initiatives all combined to lessen the need for as many inpatient services. Additionally, the expansion of VA clinics – notably the Community Based Outpatient Clinics (CBOCs) – brought care closer to veterans.

These widespread changes represented a management challenge for VA, GAO argued: "VA's massive, aged infrastructure could be the biggest obstacle confronting VA's ongoing transformation efforts. VA's challenges in this arena are twofold: deciding how its assets should be restructured, given the dramatic shifts in VA's delivery practices, and determining how a restructuring can be financed in a timely manner."

GAO also testified before the House Veterans' Affairs Committee's Subcommittee on Health in March 1999 on VA's capital asset planning process. They concluded that, "VA could enhance veterans' health care benefits if it reduced the level of resources spent on underused or inefficient buildings and used these resources, instead, to provide health care, more efficiently in existing locations or closer to where veterans live." Further, GAO found that VA was spending about 1 in 4 Medical Care dollars on asset ownership with only about one quarter of its then-1,200 buildings being used to provide direct health care. Additionally, the Department had over 5 million square feet of unused space, which GAO claims cost VA $35 million per year to operate.

From these findings, VA began the Capital Asset Realignment for Enhanced Services (CARES) process. It was the first comprehensive, long-range assessment of the VA health care system's infrastructure needs since 1981.

CARES was VA's systematic, data-driven assessment of its infrastructure that evaluated the present and future demands for health-care services, identifying changes that would help meet veterans' needs. The CARES process necessitated the development of actuarial models to forecast future demand for health care and the calculation of the supply of care and the identification of future gaps in infrastructure capacity.

The plan was a comprehensive multi-stage process.

- February 2002 – VA announced the results of the pilot program of VISN 12
- August 2003 – Draft National CARES Plan submitted to the Undersecretary for Health
- February 2004 – 16-member independent CARES Commission submits recommendations based upon its review of the Draft Nationals CARES Plan.
- May 2004 – VA Secretary announces releases final CARES Decision Document, but leaves several facilities up for further study.
- May 2008 – Final Business Plan Study released, completing the CARES process.

Throughout the process, we were generally supportive. We continuously emphasized that our support was contingent on the primary emphasis being on the "ES" – enhanced services – portion of the CARES acronym. We wanted to see that VA planned and delivered services in a more efficient manner that also properly balanced the needs of veterans. And, for the most part, the process did just that.

Our main concern with the plans as they unfolded was the lack of emphasis on mental health care and long-term care. The early stages of the CARES process excluded many of these services for the most part because they lacked an adequate model to project the need for these services in the future.

The CARES Commission called for VA to develop a long-term care strategic plan, to address the needs of veterans and all care options available to them, including state veterans homes. As we discussed in the Independent Budget, VA's 2007 Long-Term Care Strategic Plan did not address these issues in a comprehensive manner; going forward, this must be rectified.

The 2004 CARES Decision Document gave VA a road map for the future. It called for the construction of many new medical facilities, over 100 major construction projects to realign or renovate current facilities, and the creation of over 150 new CBOCs to expand cares into areas where the CARES process identified gaps.

Since FY 2004, 50 major construction projects have been funded for either design or actual construction. Eight of those projects are complete. Six more are expected to be completed by the end of FY 2009, and 14 others are currently under construction. So CARES has produced results.

The strength of CARES in our view is not the one-time blueprint it created, but in the decision-making framework it created. It created a methodology for future construction decisions. VA's construction priorities are reassessed annually, all based on the basic methodology created to support the CARES decisions. These decisions are created system-wide, taking into account what is best for the totality of the health care system, and what its priorities should be.

VA's Capital Investment Panel (VACIP) is the organization within the department responsible for these decisions. VA's capital decision process requires the VACIP to review each project and evaluate it using VA's decision model on a yearly basis to ensure that potential projects are fully justified under current policy and demographic information. These projects are assigned a priority score and ranked, with the top projects being first in line for funding.

It is a dynamic process that depoliticizes much of the decision-making process. The projects selected for funding are by and large the projects that need the most immediate attention.

Because it is a dynamic process, some of the projects VA has moved forward with were not part of the original CARES Decision Document, but they were identified, prioritized and funded through the methodology developed by CARES. We continue to have strong faith that this basic framework serves the needs of the majority of veterans. Despite its strengths, there are certainly some challenges.

First is that the very nature of the report required a large infusion of funding for VA's infrastructure. While a huge number of projects are underway, a number of these are still in the planning and design phase. As such, they are subject to changes, but they have also not received full funding.

This has resulted in a sizable backlog of construction projects that are only partially funded. Were the administration's construction request to move forward, VA would have a backlog in funding for major construction of nearly $4 billion. This means that to just finish up what is already in the pipeline, it would take approximately five full fiscal years of funding -- based on the recent historical funding levels -- just to clear the backlog.

This Congress and this Administration must continue to provide full funding to the Major Construction account to reduce this backlog, but also to begin funding future construction priorities.

Another difficulty has been the slow pace of construction. Major construction projects are huge undertakings, and in areas -- such as New Orleans or Denver -- where land acquisition or site planning have presented challenges, construction is slower than we would like. There are, however, many cases where there have been fewer challenges, and when the money was appropriated, construction has moved quickly.

With these twin problems of funding and speed in mind, VA has recently been exploring ways to improve the process. Last year, they unveiled the Health Care Center Facility (HCCF) leasing concept.

As we understand it, the HCCF was intended to be an acute care center somewhere in size and scope between a large Medical Center and a CBOC. It is intended to be a leased facility -- enabling a shorter time for it to be up and running -- that provides outpatient care. Inpatient care would be provided on a contracted basis, typically in partnership with a local health care facility.

We expressed our concerns with the HCCF concept in the Independent Budget (IB). Primarily, we are concerned that this concept -- which heavily relies on widespread contracting -- would be done in lieu of an investment of major construction.

Acknowledging that with the changes taking place in health care, VA needs to look very carefully before building new facilities. Cost plus occupancy must justify full blown Medical Centers. But leasing is the right thing to do only if the agreements make sense.

VA needs to do a better job explaining to Veterans and the Congress what their plans are for every location based on facts. The ruinous miscommunication that plagued the Denver construction project amply demonstrates this point.

While promising, the HCCF model presents many questions that need answers before we can fully support it. Chief among these is why, given the strengths of the CARES process and the lessons VA has learned and applied from it, is the HCCF model, which to our knowledge has not been based on any sort of model or study of the long-term needs of veterans, the superior one'

We also have major concerns with the widespread contracting that would be mandated by this type of proposal. The lessons from Grand Island, NE -- where the local hospital later canceled the contract, leaving veterans without local inpatient care -- or from Omaha -- where some veterans seeking specialized services are flown to Minneapolis -- show the potential downfall of large-scale contracting.

Leasing clinical space is certainly a viable option. It does provide for quicker expansion into areas with gaps in care, and it does provide the Department with flexibility in the future.

But when it is combined with the contracting issue, and presented without information and supporting documentation that is as rigorous or comprehensive as CARES was, it will be difficult for the VFW and the veteran’s community to support it.

We have seen the importance of leasing facilities with certain CBOCs and Vet Centers, especially when it comes to expanding care to veterans in rural areas. CARES did an excellent job of identifying locations with gaps in care, and VA has continued to refine its statistics, especially with the improved data it is getting from the Department of Defense about OEF/OIF veterans.

Providing care to these rural veterans is the latest challenge for the system, and the expansion of CBOCs and other initiatives can only help. We do believe, however, that much of what will improve access for these veterans will lie outside the construction process. VA must better use its fee-basis care program, and the recent initiatives passed by Congress -- such as the mobile health care vans or the rotating satellite clinics in some areas -- are going to fix some of the demand problems these veterans face.

We can always certainly do more, but thanks to the CARES blueprint, VA has greatly improved the ability of veterans around the country to access the care they earned by virtue

of their service to this country. And with the annual adjustments and reassessments that account for changes within the veterans' population, we can assure that veterans are receiving the best possible care long into the future.

The VFW thanks you and the Subcommittee for looking at this most important issue.