U.S. House of Representatives
COMMITTEE ON VETERANS' AFFAIRS
ONE HUNDRED EIGHTH CONGRESS
335 CANNON HOUSE OFFICE BUILDING
WASHINGTON, DC 20515
http://veterans.house.gov

September 3, 2003

Mr. Everett Alvarez
Chairman
Capital Assets Realignment for
Enhanced Services Commission
Department of Veterans Affairs
Washington, DC 20420

Dear Chairman Alvarez:

We are writing to bring to your attention a number of issues that we believe must be adequately addressed in order for the "Capital Assets Realignment for Enhanced Services" (CARES) process to achieve its stated goals. As you and the other members of the Commission continue your deliberations over the next couple of months, we urge you to give these issues serious consideration before you make your recommendation to the Secretary.

One of our greatest concerns about the CARES process is whether it will comprehensively address all aspects of VA health care services, including specialized medical programs such as physical medicine and rehabilitation, blind rehabilitation, traumatic brain and spinal cord injury, geriatrics and long-term care, mental health, substance abuse, and homeless programs. Realizing these specialized programs' vulnerability to managed care reforms, Congress initially mandated VA to maintain its capacity to provide these types of care when it allowed VA to change its outdated eligibility criteria for many services in 1996 under Public Law (P.L.) 104-262. Since then the requirement has been updated and enhanced under P.L. 107-135. We are no less concerned regarding the future of these core programs in the face of a major restructuring effort. We have repeatedly conveyed our view to the Department that VA must integrate detailed planning for all specialized services right from the beginning of the CARES planning process, prior to any decisions on approval of the plan.

We are especially concerned about VA's ability to provide long term nursing and geriatric care to an aging veterans population. In another sweeping legislative reform, Congress required VA to maintain the capacity of its long-term care programs at the level that existed in 1998 under P.L. 106-117. VA estimates that within the next decade there will be 1.3 million veterans requiring long term nursing home care. Does the draft national CARES proposal sufficiently plan for meeting this demand, both in national planning and in local network planning? Taking into account the significant mission

changes and closures of some major long-term care providers, will VA maintain its required nursing home bed capacity under the national draft plan?

Considering that there are more than 250,000 homeless veterans without shelter on any given night, do the network planning initiatives give proper consideration to the reuse of existing properties for domiciliary programs for homeless veterans? Furthermore, what effect will CARES have on VA's other specialized programs, including physical medicine and rehabilitation, blind rehabilitation, traumatic brain and spinal cord injury, mental health and substance abuse programs?

Given both the negative and positive effects that CARES may have on the Department's specialized medical programs, does the Commission support proposed changes in these programs as recommended by the draft national CARES plan?

In 1999 the General Accounting Office (GAO) reported to the Committee (GAO/T-HEHS-99-173, July 22, 1999) that the Department of Veterans Affairs expends $1 million per day maintaining facilities that are not needed for veterans' health care. Does the draft national CARES plan solve the reported problem of wasted capital facilities' resources, and to what extent? Once the CARES process has been concluded, assuming all the major initiatives are completed as recommended, will VA still retain these superfluous capital facilities? If so, will the Commission make any recommendations concerning the obsolete or unneeded facilities?

The national draft plan currently before the Commission is a compendium of local and regional geographic service area plans. GAO previously warned the Department that these local plans may reflect biases of local stakeholders who wish to maintain the status quo. In regard to this potential, are the local plans that make up the draft national CARES plan internally consistent—e.g., is VA recommending solutions that meet its own standards for quality and access to care in a similar manner in each of the markets it has identified?

Since the end of World War II, VA has been affiliated with the nation's medical schools as primary training grounds not only for medical students and newly graduated physicians, but also for nurses, technologists, and other key health care staff. What is the effect of the draft national CARES plan on VA's affiliations with schools of health professions? Does the Commission support these results?

With respect to the timelines for proposed improvements and renovations in VA facilities (the "Enhancements" side of CARES), what is the estimated cost of such improvements, and over what period of time? Are there reasonable assurances in each market that necessary investments in infrastructure will precede any closures—i.e., if VA

proposes to move a service to another site is that site adequately prepared and available to provide continuous services to veterans before services are discontinued at the original site? Given the annual challenge of identifying sufficient resources for VA health care through the discretionary appropriations process, are the targeted investments feasible goals?

Does the CARES process enhance the sharing of health resources between VA and the Department of Defense? GAO has previously advised the Committee of nearly two dozen sites that could support joint ventures or, at a minimum, significant new sharing initiatives between a VA facility and a sister military treatment facility. Were these opportunities identified and pursued through the CARES process? Does the Commission support the proposed plans as presented?

For the first time, in its national draft CARES plan, VA identifies some facilities it would designate as "critical access hospitals." This Medicare-defined concept describes facilities with very small acute hospital bed capacities, limited lengths of stay, and a limited range of services. VA would apparently apply this designation in a similar manner, possibly truncating the range of services available at most medical centers today. What are the implications of a critical access hospital designation for the eight facilities that have been so labeled in the draft plan? Does critical access hospital status presage closure of these facilities, especially in the case of rural veterans' needs? Does the Commission support this concept?

The draft national CARES plan assumes that up to 25% of future VA health care will be provided through contract mechanisms with local community health care resources. Today, VA expends less than ten percent of its budget in contract care. Does the Commission support this assumption of a significant increase in VA contract care?

The national draft plan projects the need for two new inpatient facilities, one in Florida and one in Nevada. This plan also proposes the closure of approximately 25 major VA facilities elsewhere. Does the Commission agree with these findings?

The initial phase of CARES focused on VA network 12, which includes the city of Chicago and other parts of Illinois, parts of northern Indiana, the Upper Peninsula of Michigan, and most of the state of Wisconsin. Is the national draft CARES plan consistent with the results of the VISN 12 plan?

The Committee appreciates the efforts of the Commission in attempting to answer these and other questions about the CARES process. Should this Committee hold future hearings dealing with CARES, these will be among the questions we will pose to the Department and to members of your Commission who may be called to testify. Thus, we would appreciate your broaching such questions as the Commission completes its review

of the draft national CARES plan and makes its report to the Secretary of Veterans Affairs.

Sincerely,

CHRISTOPHER H. SMITH

LANE EVANS