



KENTUCKY DEPARTMENT OF VETERANS' AFFAIRS

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COMMISSIONER

July 23, 2003

Layton McCurdy, M.D.
CARES Commissioner
810 Vermont Avenue, NW
Washington, D.C. 20420

Dear Commissioner McCurdy:

Request your assistance in correcting a discrepancy in the reimbursements allowed State Veterans Nursing Homes for long term care services rendered for a specific category of disabled veterans under Public Law 106-117, the Veterans' Millennium Health Care and Benefits Act. Rectification of an inequitable situation wherein State Veterans Homes are not part of the placement options needs correction. This is not being sought for the benefit of our State Veterans Homes per se, but rather for those most deserving, service connected disabled veterans.

By way of background, PL 106-117, **requires VA to provide nursing home care to any veteran who is in need of such care and: (1) is seeking nursing home care for a service connected, disabling condition; (2) has a combined service connected disability rating of 70 percent or greater; (3) is rated 60 percent service connected and unemployable; or (4) is rated 60 percent service connected and permanent and totally disabled.**

VA promulgated VHA Directive 2002-077, Eligibility and Expansion of Nursing Home Care, to implement PL 106-117. This directive prescribes that VHA will provide nursing home care, **either directly or through contracts**, to disabled veterans in the above categories when clinically indicated. Under the Contract Nursing Home Program, VA pays participating nursing homes the full cost of a veterans care at negotiated rates. Further as outlined within VHA Directive 2002-065, Implementation of Co-Payments for Extended Care Services Provided to Veterans by VA, veterans with a compensable, service-connected disability are exempt from co-payments for extended care services provided by VA-operated facilities and contract nursing homes.

In addition to directly paying for nursing home care, VA also provides support to State Veterans Nursing Homes through two separate grant programs. Under the construction program, states may request grants from VA to assist with construction and renovation of state home facilities. These grants may total up to 65 percent of the cost of construction/renovation. Under the second grant program, the per diem program; VA pays a daily per diem fee (currently \$56.24) to the state for each veteran receiving care in a state home. These per diem payments are limited to no more than 50% of the veterans' cost of care.



AN EQUAL OPPORTUNITY EMPLOYER M/F/D

Commissioner Layton McCurdy, M.D.
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Relative to Kentucky's State Veterans Homes, these per diem payments account for approximately one third of our total annual operating funds. Another third of our funding comes from the Commonwealth of Kentucky in the form of General Funds and the final third is received from monthly charges to residents. Each resident is charged on an ability to pay basis without regard to service connected disability status, with a maximum charge of \$2,900 per month. Although each state differs in how resident charges are computed, the manner in which Kentucky's veterans centers are funded is typical of that found in the majority of state homes across the nation.

In light of the above payment methodologies, severely disabled veterans have a strong financial incentive to select either a VA-operated or contract nursing home (where they are exempt from co-pays) for their long term care needs over a state veterans nursing home where they are assessed a monthly resident charge. This inequitable situation could readily be corrected by making State Veterans Homes an option under VA Directive 2002-077 for any veteran needing nursing home care who meets the service connected disability criteria identified above. Reimbursement to state homes would then be the full cost of care as negotiated with the VA Medical Center and forego the customary VA per diem payment. Most importantly, this would allow eligible veterans under PL 106-117 to reside in state homes built and operated specifically to serve veterans and do so free of charge.

Unfortunately, previous attempts by state officials to pursue this much needed policy change have been blocked by an October 2000 VA General Council ruling which concludes that state homes cannot participate in the contract nursing home program because of the construction and per diem grant programs mentioned above. In short, paying for care in state homes at negotiated contract nursing home rates is seen as changing the Federal/State cost sharing arrangement intended by Congress when the State Homes Grant Program was initially created. Now is the time to reconsider this General Council ruling and grant our disabled veterans equity of access to long-term care in the most medically and functionally appropriate location e.g., VA Nursing Home, Contract Home, **or State Veterans Home.**

I seek your support in making necessary changes to VA Directive 2002-077 to give our severely disabled veterans the freedom of choice in obtaining extended care services that they have earned and so richly deserve. Clearly, this is the right thing to do for this special group of patriots from a financial, quality of life, and quality of care perspective. If I can be of further assistance in this matter, please do not hesitate to contact me at 1-800-572-6245.

Respectfully,

Leslie E. Beavers
BG, U. S. Army Retired
Commissioner, KDVA

Enclosure: NASDVA Resolution



*The National Association of
State Directors of Veterans Affairs, Inc.*

RESOLUTION

WHEREAS, the U. S. Department of Veterans Affairs (VA) will pay the full cost of nursing home care for any veteran 70% service-connected disabled or greater, if it is determined by the VA that the veteran requires skilled nursing care; and

WHEREAS, currently this benefit is only available if the 70% service-connected disabled or greater veteran requires skilled nursing care and accepts admission to a VA or community contracted nursing home; and

WHEREAS, this benefit is not extended to any one of the 102 State Veterans Homes in the United States, but only to community contracted nursing homes; and

WHEREAS, this will force veterans who would prefer to reside in a State Veterans Home to choose between the State Veterans Home where there is a significant charge payable by the veteran for the care provided and a community contracted nursing home where there is no charge to the veteran; therefore, be it

RESOLVED, by the NASDVA in Annual Convention assembled in Charleston, SC on September 18, 2002, that Congress allow State Veterans Homes to admit/retain any eligible veteran who is 70% or greater service-connected disabled and requires skilled nursing care and to receive the full cost of care for the veteran from VA. The State Veterans Home would relinquish the Federal State Home Per Diem and require no resident charge for those veterans who qualify for the higher benefit.

Submitted by the Department of Rhode Island
To Committee on VETERANS SERVICE RESOLUTIONS

The intent of this resolution is:

To support Legislation to allow VA to pay the full cost of nursing home care for veterans 70% service connected disabled or greater who choose to reside at State Veterans Nursing Homes.

Raymond G. Boland
President, NASDVA

*Katy
McBride*

White Paper

Department of Veterans Affairs
Veterans Health Administration

Louisville Veterans Affairs Medical Center
and
Department of Defense
Sharing Agreements
July 23, 2003

Purpose:

This paper offers a brief background and historic development of the Fort Knox VA/DoD Sharing Agreement Program currently being utilized between the Veterans Affairs Medical Center (VAMC), Louisville, Kentucky and the Ireland Army Community Hospital (IACH), Fort Knox, Kentucky.

Background:

The Louisville VAMC and Fort Knox IACH have long recognized the opportunities for greater sharing of the healthcare resources between the VA and DoD to achieve cost savings to the government as well as to increase access to both beneficiary groups. The Louisville VAMC has engaged in sharing agreements with Fort Knox IACH covering referrals to radiology and inpatient psychiatry since the late 1980's; however, it was not until 1996 when the scope of the sharing agreements expanded prior to the introduction of the DoD Tricare program at Fort Knox IACH.

In 1996, the Louisville VAMC and the Fort Knox IACH entered into an agreement in which VA would staff and manage a primary care clinic with an empanelment of 6500 beneficiaries for Fort Knox IACH. In turn, the VA was given clinical space, medical equipment and supplies, computers, diagnostic testing, and an initial 30-day fill on all prescriptions for a Community Based Outpatient Clinic (CBOC) with an empanelment of 3,500 beneficiaries. This was a resource neutral agreement as no money was exchanged for services. In 1998, when one of the Fort Knox IACH contract clinics failed to meet contractual standards and became too costly, the Louisville VAMC expanded this sharing agreement to include the management of 14,500 patients and began accepting reimbursement. Since this time Louisville VAMC and Fort Knox IACH have aggressively pursued and expanded their sharing agreement program.

Today, at Fort Knox IACH, the Louisville VAMC manages 55% of all primary care outpatient clinic visits. Additionally, the Louisville VAMC is responsible for approximately 39% of all outpatient psychiatric visits, 27% OB and 27% GYN visits, 47% orthopedic outpatient visits, 41% of orthopedic same day surgeries, 31% of internal medicine outpatient clinic visits and 44% of podiatry workload.

Closing:

The Fort Knox VA/DoD Sharing Program continues to play a significant role in gaining outside revenues for the Louisville VAMC while reducing the cost and overhead of Fort Knox IACH on contractor performance of core functions. These sharing agreements provide a cost effective means to achieve these goals for both organizations while also increasing access to both beneficiary groups. With the anticipation of additional sharing agreement opportunities, both the Louisville VAMC and Fort Knox IACH continue to aggressively seek new and innovative ways to integrate the two healthcare systems.

Prepared by:
Jodie D. Babb
Chief Administrative Officer
Fort Knox VA/DoD Sharing Office

**VA/DoD Sharing Agreement Program
Fort Knox, Kentucky
Ireland Army Community Hospital**

Master Agreement

AMENDMENTS

- 1. Primary Care Clinic**
- 2. Behavioral Health Services**
- 3. Women's Health**
- 4. Oncology Case Mgmt Educator**
- 5. Prenatal Nurse Educator**
- 6. Orthopedic Surgeon**
- 7. Orthopedic PA**
- 8. Orthotics Services**
- 9. Audiology Services**
- 10. Endoscopy Services**
- 11. Radiology Services**
- 12. Radiology Technician**
- 13. Radiology Transcription Services**
- 14. Internal Medicine Physician (1)**
- 15. Internal Medicine Physician (2)**
- 16. Urological Surgeries**
- 17. IPCC #1 Staff Physician-Family Practice**
- 19. Podiatrist**
- 20. Neurology Testing Services**
- 21. Neurologist**
- 24. Inpatient Services**
- 25. Mental Health Counselor**
- 26. Radiation Protection Officer**
- 27. Ophthalmologist**
- 30. Internal Medicine Physician (3)**
- 31. Hematology/Oncology**
- 32. Mobile MRI**

**STATEMENT OF
M. SCOTT STAMPER
ASSISTANT SUPERVISOR OF THE
NATIONAL SERVICE OFFICE,
LOUISVILLE, KY,
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
CAPITAL ASSETS REALIGNMENT FOR ENHANCED SERVICES COMMISSION
LEXINGTON, KENTUCKY
SEPTEMBER 8, 2003**

Mr. Chairman and Members of the Commission:

On behalf of the local members of the Disabled American Veterans (DAV) and its Auxiliary, we are pleased to express our views on the proposed Capital Assets Realignment for Enhanced Services (CARES) Market Plans for this area in VISN 9.

Since its founding more than 80 years ago, the DAV has been dedicated to a single purpose: building better lives for America's disabled veterans and their families. Preservation of the integrity of the Department of Veterans Affairs (VA) health care system is of the utmost importance to the DAV and our members.

One of VA's primary missions is the provision of health care to our nation's sick and disabled veterans. VA's Veterans Health Administration (VHA) is the nation's largest direct provider of health care services, with 4,800 significant buildings. The quality of VA care is equivalent to, or better than, care in any private or public health care system. VA provides specialized health care services—blind rehabilitation, spinal cord injury care, posttraumatic stress disorder treatment, and prosthetic services—that are unmatched in the private sector. Moreover, VHA has been cited as the nation's leader in tracking and minimizing medical errors.

As part of the CARES process, VA facilities are being evaluated to ensure VA delivers more care to more veterans in places where veterans need it most. DAV is looking to CARES to provide a framework for the VA health care system that can meet the needs of sick and disabled veterans now and into the future. On a national level, DAV firmly believes that realignment of capital assets is critical to the long-term health and viability of the entire VA system. We do not believe that restructuring is inherently detrimental to the VA health care system. However, we have been carefully monitoring the process and are dedicated to ensuring the needs of special disability groups are addressed and remain a priority throughout the CARES process. As CARES has moved forward, we have continually emphasized that all specialized disability programs and services for spinal cord injury, mental health, prosthetics, and blind rehabilitation should be maintained at current levels as required by law. Additionally, we will remain vigilant and press VA to focus on the most important element in the process, enhancement of services and timely delivery of high quality health care to our nation's sick and disabled veterans.

Furthermore, local DAV members are aware of the proposed CARES Market Plans and what the proposed changes would mean for the community and the surrounding area. A beneficial proposal of the market plans is the construction of a new Medical Center for the Louisville area proposed as being co-located with the University of Louisville. The current medical center has been rated the poorest of all the facilities in the VISN based on its current infrastructure. The physical plant and the poor functional design contribute to the inefficiency of the health care process. The Louisville VA Medical Center (VAMC) does represent the largest portion for potential growth in the Northern Market of VISN 9, but the location of the medical center, combined with property limitations leave no room for expansion. Recent information has indicated that continued upkeep and modernization of this facility would not be financially feasible and/or advantageous. The demand for services exceeded functional capacity several years ago, resulting in 85% of all primary care and 100% of all outpatient mental health care being provided off site at community-based clinics. Additionally, Ireland Army Hospital located on Fort Knox is located within the primary service area of the Louisville VAMC and a sharing agreement to provide primary care and certain specialty care services is in effect, adding an additional workload to an already over-extended facility. The DAV will continue to support the proposed construction of a new facility co-located with the University of Louisville in providing an updated facility to provide a higher level of medical services that our country's disabled veterans deserve.

Lexington has two facilities that complement each other to provide care. The Leestown and Cooper Drive facilities have consolidated similar programs for several years to maximize the provision of health care by exercising the strengths of each. Cooper Drive adjoins the University of Kentucky and provides modern facilities to support acute care medicine, surgery, and specialty care. The space limitations at Cooper Drive have prevented entire relocation of services and the closure of the Leestown facility. Leestown is an older facility that is designed with multiple buildings connected by corridors. This facility is utilized primarily for long-term care and is a referral source for other medical centers in the Network for long-term care. Alcohol and drug treatment programs as well as primary care and other functions are provided at Leestown. Eastern State Hospital (ESH) has proposed to establish an enhanced-use lease agreement with the Lexington Medical Center that would allow relocation of the entire ESH operation to the Lexington site. This would generate a positive revenue stream to the facility and reduce costs that are already handled strictly by the medical center such as utilities, recurring maintenance, trash removal, grounds keeping, and parking, to name a few. ESH is also interested in either purchasing services or leasing additional space for their operations, such as various medical testing and services, food production, linen, and extended maintenance and repair services. This is proposed as a minimum 20-year lease that has the possibilities of opening other avenues within the agreement to provide further revenues to come into the Lexington facility and provide for overall better care for our disabled veterans. This seems to provide a win/win situation for all parties involved.

In closing, the local DAV members of VISN 9 sincerely appreciate the CARES Commission for holding this hearing and for its interest in our concerns. We deeply value the advocacy of this Commission on behalf of America's service-connected disabled veterans and their families. Thank you for the opportunity to present our views on these important proposals.

**Realignment/Consolidation of VAMC
Lexington and other VISIN 9
Northern Market CARES Initiatives**

Comments from VFW Department of Kentucky.

Thank you for the opportunity to make this presentation.

Lexington VAMC is a two division tertiary level medical center that provides acute and extended care.

Acute medical, neurological, surgical, psychiatry and rehabilitation medical services are provided at the Cooper Drive Division located adjacent to the University of Kentucky Medical Center. The Leestown Division, which is only five miles from Cooper Drive, offers nursing home care as well as primary care and several outpatient mental health services, including substance abuse treatment and PTSD care. Also Leestown Division is a referral source for long term care for other VAMC's in the Network.

DRAFT PROPOSAL: Leestown services of outpatient care and nursing home care will be transferred to Cooper Drive, as space is available. Due to possible space limitations at Cooper Drive, it may be necessary to relocate some outpatient primary care and outpatient mental health services to alternative locations other than Cooper Drive. VA will no longer operate health care services at Leestown. The possibility exists for the leasing of Leestown Campus to the state with lease revenue remaining in the VISIN to invest in Veterans services.

Other proposals include expanding the Fort Knox outpatient clinic to provide additional primary care and outpatient mental health, increase the use of telemedicine for specialty care needs, expand existing outpatient clinics to include mental health and increase the use of community contract services.

DRAFT PROPOSAL COMMENTS: If Cooper Drive Division is unable to absorb these services that are now being provided at the Leestown Division, where will these services be provided for veterans that need outpatient mental health care and substance abuse treatment? Contracting these services to private mental health care practitioners would not be beneficial to the veteran, because they don't have the training that the VA doctors have in these dual specialties. Also these patients have a more difficult time adjusting to changes in treatment environment.

Can the Cooper Drive Division absorb the primary services now being offered at Leestown? If not, where will these services be provided? If the distance to these services becomes greater than they are presently this would add a considerable burden to a great number of these veterans as they are of advancing years and transportation is a problem for them.

Will the Cooper Drive Division be able to absorb the nursing home care patients? This question is necessary because Congress has mandated that the VA provide this care to certain patients.

We would accept the leasing of the majority of the Leestown Campus to the state because the lease proceeds would be used for veterans services. However only if our other concerns above would be resolved.

We support the proposal to expand FT. Knox for additional services. And we also support the use of community contract services, however mainly for just primary care.

The main issue in this CARES initiative is that the SERVICES TO OUR VETERANS MUST BE ENHANCED not reduced.

**Wayne C. Dwyer
Commander
Department of Kentucky-VFW**

**STATEMENT OF
RANDALL FISHER, SERVICE OFFICER
THE AMERICAN LEGION
BEFORE THE
CAPITAL ASSET REALIGNMENT FOR ENHANCED SERVICES
(CARES) COMMISSION
ON
THE DRAFT NATIONAL CARES PLAN**

SEPTEMBER 8, 2003

Mr. Chairman and Members of the Commission:

Thank you for the opportunity today to express the local views of The American Legion on the Department of Veterans Affairs' (VA)'s Capital Asset Realignment for Enhanced Services (CARES) initiative as it concerns Veterans Integrated Services Network (VISN) 9. As a veteran and stakeholder, I am honored to be here today.

The CARES Process

The VA health care system was designed and built at a time when inpatient care was the primary focus and long inpatient stays were common. New methods of medical treatment and the shifting of the veteran population geographically meant that VA's medical system was not providing care as efficiently as possible, and medical services were not always easily accessible for many veterans. About 10 years ago, VA began to shift from the traditional hospital based system to a more outpatient based system of care. With that shift occurring over the years, VA's infrastructure utilization and maintenance was not keeping pace. Subsequently, a 1999 Government Accounting Office (GAO) report found that VA spent approximately \$1 million a day on underused or vacant space. GAO recommended, and VA agreed, that these funds could be better spent on improving the delivery of services and treating more veterans in more locations.

In response to the GAO report, VA developed a process to address changes in both the population of veterans and their medical needs and decide the best way to meet those needs. CARES was initiated in October 2000. The pilot program was completed in VISN 12 in June 2001 with the remaining 20 VISN assessments being accomplished in Phase II.

The timeline for Phase II has always been compressed, not allowing sufficient time for the VISNs and the National CARES Planning Office (NCPO) to develop, analyze and recommend sound Market Plan options and planning initiatives on the scale required by the magnitude of the CARES initiative. Initially, the expectation was to have the VISNs submit completed market plans and initiatives by November, 2002, leaving only five months to conduct a comprehensive assessment of all remaining VISNs and develop recommendations. In reality, the Market Plans were submitted in April 2003. Even with the adjustment in the timeline by four months, the Undersecretary for Health found it necessary in June 2003, to send back the plans of several VISNs in order for them to reassess and develop alternate strategies to further consolidate and compress health care services.

The CARES process was designed to take a comprehensive look at veterans' health care needs and services. However, because of problems with the model in projecting long-term care and mental health care needs into the future, specifically 2012 and 2022, these very important health care services were omitted from the CARES planning. The American Legion has been assured that these services will be addressed in the next "phase" of CARES. However, that does not negate the fact that a comprehensive look cannot possibly be accomplished when you are missing two very important pieces of the process.

The American Legion is aware of the fact that the CARES process will not just end, rather, it is expected to continue into the future with periodic checks and balances to ensure plans are evaluated as needed and changes are incorporated to maintain balance and fairness throughout the health care system. Once the final recommendations have been approved, the implementation and integration of those recommendations will occur.

Some of the issues that warrant The American Legion's concern and those that we plan to follow closely include:

- ? Prioritization of the hundreds of construction projects proposed in the Market Plans. Currently, no plan has been developed to accomplish this very important task.
- ? Adequate funding for the implementation of the CARES recommendations.
- ? Follow-up on progress to fairly evaluate demand for services in 2012 and 2022 regarding long-term care, mental health, and domiciliary care.

VISN 9 – NORTHERN MARKET

There are three medical centers that service the 102 counties that comprise the Northern Market and they are the Louisville VA Medical Center, Lexington, which is a two division hospital (Cooper Drive Division, and Leestown Division), and the Huntington, VA Medical Center. The Northern Market is primarily in Kentucky and West Virginia.

Access

While many veterans in the Northern Market do not have access to primary care in accordance with the CARES criteria, the Draft National Plan (DNP) does not propose the establishment of any Community Based Outpatient Clinics (CBOCs) to alleviate the problem. The American Legion is concerned the needs of these veterans will not be taken care of.

Campus Realignment/Consolidation of Services

The DNP proposes to close the Leestown Division of the Lexington VA Medical Center and transfer outpatient care and nursing home care to the Cooper Drive Division. VA has already identified inadequate space issues at the Cooper Drive Division and suggests that it may be necessary to relocate some outpatient primary care and outpatient mental health psychiatric services to alternative locations other than Cooper Drive.

The American Legion cannot support this proposal under this plan. Uprooting the veterans in such a manner, without a complete plan does not make sense. Parking at Cooper is inadequate. There is no room to move the 61 beds from Leestown to the Cooper Division. For the last five years, we have watched as service after service has been closed at Leestown while we were being told that it would not closed. As a result of the cut in services demand has gone down and there have been fewer reasons why veterans would use the campus. Years of artificial suppression of demand have led to the proposal to close this hospital.

The American Legion does not understand how outpatient mental health services can be moved, when accurate projections and numbers are not available yet regarding demand for services in Fiscal Year (FY) 2012 and FY 2022. The CARES planning model projections for outpatient mental health, long-term care, and domiciliary were inaccurate from the beginning, and these services were not to be included in the CARES initiative until the next “phase”. We believe the realignment and proposed closure of this facility is premature. As in the past, The American Legion believes VA will close down the facility before ensuring services are properly transferred and veterans are being taken care of in their new location.

We have an excellent hospital in Leestown. Mental Health, Primary Care and long-term beds are still here. Where would veterans go for these services if it were to be closed? Are we going to rent space in the private community or contract these services out? If so, that is one step closer to dismantling the entire VA system. VA is a provider of health care, not a purchaser of health care. Contracting out of care is not the answer.

Psychiatry

To meet the growing demand of inpatient psychiatry services the DNP proposes to centralize the services to one site or refer patients to the Murfreesboro, TN program. However, VA is uncertain where the centralized location will be. It may be part of an

enhanced use lease agreement with the state of Kentucky or they are considering consolidating services to the Louisville VA Medical Center. This is just another example of no real plan.

Thank you for the invitation to present testimony on such an important issue.