

**U.S. Department of Veterans Affairs  
Capital Asset Realignment for Enhanced Services (CARES) Commission**

Fourth Meeting  
May 13-14, 2003  
Washington, DC

**Commissioners in Attendance:**

The Honorable Everett Alvarez, Jr., Chairman  
Charles Battaglia  
Joseph E. Binard, MD, FRCSC  
Raymond Boland  
Chad Colley  
Vernice Ferguson, RN, M.A.  
John Kendall, MD  
Richard McCormick, PhD  
Richard Pell, Jr.  
Robert A. Ray  
Sister Patricia Vandenberg, CSC  
The Honorable Raymond John Vogel, Vice Chairman  
The Honorable Jo Ann Webb, RN, MHA  
Michael K. Wyrick, Major General, USAF (Ret.)  
Al Zamberlan, FACHE

Richard Larson, Executive Director

**Tuesday May 13, 2003**

The Chairman opened the session and reviewed the agenda for the meeting. The main items of business for this meeting are:

- Deciding whether NCPO acted reasonably in identifying gaps and selecting planning initiatives.
- Preparing the Commission to make a decision about the CARES demand model at the next meeting.
- Hearing from additional stakeholders and information sources.
- Reaching agreement on a hearing schedule (dates, places, Teams and related site visits) for publication in the *Federal Register*.
- Establishing a process for reviewing and analyzing the market plans that will be published as a draft national plan in June.

The Chairman announced that the session to discuss how to deal with the CARES model would be a closed session; all other sessions will be open.

## NCPO Selection of Gaps and Planning Initiatives

The decision to be made, which is the first of three major decisions the Commission will make, was whether (NCPO) reasonably adhered to uniform application of policy guidance and applied the data consistently when establishing the CARES planning initiatives (PIs). /The criteria that were contained in the CARES Guidebook for identifying Planning Initiatives. They specified that data from the network market analysis were to be used to identify:

- Apparent future gaps between supply and demand both geographically and in the number of resources required.
- Opportunities for sharing with DoD, VBA and NCA.
- The need to find uses for excess vacant space.
- Other specific strategic program issues, such as the future need and location of specialty referral services, enhanced use opportunities, emergency preparedness and Homeland Security and contingency backup.

The 351 Planning Initiatives that were reviewed during the April 2003 meeting of the Commission compared all PIs to the criteria established by the NCPO in 4 broad categories:

- Inpatient care.
- Outpatient care.
- Non-clinical areas, such as research and administrative.
- Special disability programs.

The review found 328 of the 351 PIs to be acceptable and highlighted the need for further review of 23 PIs.

The Commission asked NCPO to clarify the selection of the 23 anomalous PIs and to address two types of issues that emerged from the review: (1) inconsistent planning initiative selection across all Networks, and (2) the consistent non-selection of mental health PIs.

The Commission is being asked to decide that *NCPO reasonably adhered to uniform application of policy guidance and consistently applied data when establishing planning initiatives.*

An additional issue had arisen concerning the development of market plans based on the policy guidance. The additional concerns do not change the conclusions specified above, but do provide for strategic discussion of certain areas during the public hearings (such as mental health). This issue will be discussed with the Commission later in the meeting during the discussion of field hearing strategies.

### Q&A/Discussion

The Chairman reminded the Commission that the issue with the 23 PIs had been of two types: (1) gaps that met the criteria but were not selected as Planning Initiatives, and (2) gaps that did not meet the criteria but were selected as Planning Initiatives anyway. In each of these cases, the Staff had asked NCPO for further explanation, additional information and a justification of their decision. The NCPO response was that NCPO guidance required the Networks to look at all identified gaps. NCPO indicated that, in developing Planning Initiatives, the Networks had generally selected the largest gaps and tried to meet those needs. But the guidance to consider all gaps was followed.

A question was raised as to whether the decisions were consistent for both types of anomalies; the response was that they were consistent. Noting that 13 of the 23 anomalous PIs had been in the mental health area, a Commissioner asked about NCPO's explanation for this. The staff said that there was a varied response, but, for the most part, NCPO didn't believe that the mental health gaps were the biggest. Another Commissioner noted that this wasn't always the case and, in addition, the NCPO used data that understated the size of the mental health gaps. The Chairman asked to have someone from NCPO invited to address the Commission on this matter sometime during the meeting.

Commission discussion also raised questions about the so-called "rule of the three," which limited each market to three planning initiatives, and whether the guidance was appropriate. The Staff noted that the VISNs had consistently chosen three initiatives, plus special VISN-wide projects (such as opportunities for collaboration). In answer to a Commission question, it was also noted that determining whether the initial guidance had been appropriate was outside the scope of the Commission. The Commission's role is to determine whether policy guidance had been followed in developing the PIs. The Commission agreed that it would like to have additional explanation for why a limit of three PIs had been imposed before it goes out for field hearings.

VISNs were given some discretion in selecting PIs. NCPO viewed CARES as a living, growing process. Input was received from multiple sources, and choosing PIs to be included in the CARES program was neither easy nor simple. In the case of possible mental health initiatives, NCPO was aware that the Networks already had projects in progress in some cases; they didn't interfere with these. One difficulty for headquarters was that the treatment of mental health services differs from one VISN to the next.

Further discussion led to the observation that it is difficult to reconcile the "data-driven" approach used for most of the process with the need to incorporate human judgment. Another Commissioner commented that the result of giving the VISNs discretion was that there is no over-arching plan that ties everything together. Mr. Larson noted that the draft national plan for CARES should perform the function of tying things together. Another Commissioner noted that, even so, the Commission would be going into the field with only "half a loaf" because it won't be dealing with long-term care, which might have a greater impact on space and facilities than the PIs now being developed. Another Commissioner expressed discomfort with having this element left out of the model.

The Commission agreed that the foregoing discussion pointed up the importance of the field hearings. The Commissioners expect that they will not provide the needed perspective, but will also reveal a lot of variations and pet projects.

At the Chairman's request, the Director of NCPO, Mr. Jay Halpern, met with the Commission later in the meeting and responded to the two questions raised above – the "rule of three" and the lack of mental health PIs. He said developing market plans meant doing a lot of work and that the time available to do it was very short. The limit of three was meant to keep the workload reasonable for the Networks and ensure the quality of what was submitted. Special exceptions were allowed and additional processes are available for important proposals that didn't fit into this round of CARES. Regarding a possible mal-distribution of initiatives in the mental health area, Mr. Halpern acknowledged that the fact that NCPO was having difficulty with the model

for mental health (NCPO was unable to develop any credible demand methodology) might have introduced a bias into the PI selection process at the VISN level. It was agreed that it would be appropriate for the Commission to address this issue further during its public hearings. The draft National CARES plan should represent more than just a “bundling together” of individual initiatives. The Commission again expressed its concern that with long-term care and some specialty care excluded from the scope of the draft national plan, it will be difficult to tie everything together in a meaningful way.

**Presentation By  
Dr. Alfonso Batres, Director, Veterans Center Program**

Dr. Batres provided the Commission with highlights of the Vet Center program, characterizing it as “an important component of service delivery in VA.” The program was established by statute (PL 96-22) in 1979 and was made permanent in 1988 (PL 100-322). Established specifically for Vietnam veterans, the program was expanded to include all veterans in 1996 (PL 104-262) when eligibility for all VA health care was changed.

The program operates 206 centers located in all 50 states. All are community based. The program has the unique mission of providing non-medical community-based counseling to both veterans and their families. It also refers veterans and their families to other VA and community services.

Dr. Batres said the VA system can be overwhelming. Vet Centers help veterans navigate the bureaucracy to reach the help they need. They provide a safe, non-bureaucratic place for veterans and women to go who would otherwise not seek treatment. Vet Centers do not have the long wait times associated with VA medical services – the average wait time for assistance in a Vet Center is 15 minutes. Their confidential records system encourages veterans to come in by avoiding the stigma associated with seeking mental health services. The Centers provide veterans with a “bridge” to care. By being located in the community (some are collocated with CBOCs, others are the only VA unit in their locality), Centers are easily accessible. These characteristics have earned the Centers a 91.7 percent customer satisfaction rating. Additionally, the Centers meet the “gold standard” for employee satisfaction.

Vet Centers get approximately one million visits a year, 130,000 of which are from first-time visitors. Of this total:

- About 45,000-50,000 veterans get what they want or need (such as information and education literature) without going to another VA facility;
- Over 190,000 veterans are referred to VA medical centers;
- Over 200,000 are referred for other kinds of medical services (VA and non-VA); and
- About half are reconnected with their support facility.

Most Vet Center users are combat veterans. Dr. Batres said it is a myth that all veterans who use Vet Centers are angry. Eighty percent of Vet Center employees are veterans themselves who understand the hardships of those who come in and appreciate their contributions. If they need other care, the Vet Center staff makes appropriate referrals.

Three or four people staff a typical Vet Center; 80 percent of the Vet Center budget goes for staff.

Dr. Batres said Vet Centers are a cost-effective program that have often been studied and used as models by other countries, such as El Salvador, and by other Government agencies, such as DoD. He invited and urged the Commission to visit a Vet Center when it goes out for field hearings.

### Q&A/Discussion

In response to Commission questions, Dr. Batres said Vet Centers are not explicitly included in CARES, but he thinks the Commission will hear about them when they go into the field because they are in touch with the community. He also said Vet Centers have been used to help select locations of CBOCs in the past.

Regarding the size of Vet Centers, Dr. Batres said the average staff size is four, and some are as large as six employees. Employees are licensed psychologists, social workers or allied professionals. The factors involved in the location of Vet Centers are “cost” and “centrality of access to care.” He also said veterans appreciate the atmosphere they find in Vet Centers.

Dr. Batres said the Vet Centers report to the Under Secretary for Health as an independent line organization. The main things they do are to help veterans obtain jobs and benefits, help families find employment, help veterans with readjustment issues and provide family services. State employment services staff are often co-located with Vet Centers. Vet Centers have also done some preventive programs and have conducted medical screenings (such as screening Navajo veterans in Arizona). Vet Centers provide assistance to homeless vets by partnering with community programs as well as the VA homeless program. Vet Centers also administer a contract post-traumatic stress disorder services program.

Although the Vet Centers have not been directly involved in the CARES process, they are trying to engage more in the planning process for outpatient mental health. They have also been pioneers in the field of telemedicine. Dr. Batres expects they will assist in implementing some of the expected CARES recommendations.

### **Discussion With Model Contract Staff**

The meeting was closed to the public for the Commission’s discussion with contract staff about the CARES demand model in order to allow the Commission to provide guidance and instructions to the staff.

**Presentation By  
Kevin Lambretta and  
General Rob Claypool  
Office of Policy, Planning and Preparedness  
Department of Veterans Affairs**

**VA's Fourth Mission and The Potential Impact of  
Security Issues on Health Care Delivery**

With the Assistant Secretary, General Kicklighter, called away for an emergency preparedness exercise, Mr. Lambretta and General Claypool met with the Commission to address two issues raised by the Commission in earlier meetings: VA's fourth mission – backup for DoD – and the possible impact of emergency preparedness programs on VA's health care system.

The presentation emphasized the primacy of VA's three main missions -- providing health care, benefits and a dignified resting place to veterans. The "fourth mission," providing a contingency hospital system for DoD and national disaster support, has been on VA's agenda since 1982, but the events of September 11, 2001, changed its focus. It is now necessary to safeguard VA employees and facilities so they can continue to operate during any emergency. The challenges this poses include:

- Protecting veterans, visitors, and VA staff, facilities and infrastructure.
- Ensuring the continuity of VA operations.
- Supporting DoD and other federal agencies in time of war or national emergency.
- Supporting local communities where VA operates.

Mr. Lambretta pointed out that VA is a nation-wide organization that consequently has a national responsibility in times of emergency. VA now has staff assigned to readiness centers, including a 24/7 undisclosed location, as part of its emergency preparedness and "continuity of government" responsibilities. In addition, the Secretary reorganized the former Office of Policy and Planning to the Office of Policy, Planning and Preparedness to emphasize its new focus. The Office's mission includes (1) security and protection of veterans, employees and facilities; (2) continuity of operations in support of VA's three primary missions; (3) VA's role in ensuring the continuity of government; and (4) VA's fourth mission – DoD contingency support and support for Federal disaster response.

Mr. Lambretta detailed the Office's five operations sites and their functions. *Site A*, the VACO Readiness Operations Center, is located at headquarters and provides an immediate response capability twenty-four hours a day, seven days a week. It has complete information collection, analysis and dissemination capabilities. *Site B*, located in Martinsburg, West Virginia, is the agency's primary COOP (continuity of operations) site and EMSHG (Emergency Management Strategic Healthcare Group) headquarters. It is a critical location that has 24/7 on-call staffing and can be activated on short notice. *Site C*, located in Richmond, Virginia, is the agency's secondary COOP site and fulfills the requirement to identify a reconstitution site. In the event VACO is destroyed, this site would perform its functions. *Site D* is a classified site. It operates 24/7 using employees detailed from other locations and also provides for continuity of operations. *Site E* is the VACO mirror site, which became operational on March 8, 2002. In the event the VACO Operations Center ceases to function, this site would house senior regional officials designated in order of succession. Mr. Lambretta said the functionality of these sites is

tested twice a week. There are representatives from all organizations at all sites, but not all sites are fully staffed around the clock.

Regarding VA's *emergency missions*, Mr. Lambretta emphasized again that continuity of operations and services to veterans (VA's first three missions) and protection of facilities is the main focus. The so-called "fourth mission" of VA includes:

- The VA/DoD contingency hospital system.
- VA roles and responsibilities under the *Federal Response Plan*.
- VA roles and responsibilities under the National Disaster Medical System.

Through the *contingency hospital system*, VA medical centers serve in a supporting role to 59 DoD installations. In all, 65 primary receiving centers, 66 secondary support centers and 58 installation support centers (all close to DoD installations) are responsible for making 6,000 VA beds available to DoD within 30 days in the following five categories: ICU, medical critical care, psychiatric beds, pediatric beds and burn beds. Mr. Lambretta noted that VA was not asked to make any of these beds available to DoD during the Iraqi Freedom campaign. He also said VA has 15,000 employees who are either active National Guard or Reserve members (7,000) or retired military (8,000). Most of those employees work in the Veterans Health Administration. About 6,000 of these VA employees were mobilized or activated during the recent crisis, and VA has reorganized its staff to manage that situation.

#### Q&A/Discussion

Several Commissioners asked what DoD's explanation has been for not using VA services and facilities during the Iraq campaign. General Claypool said the number of casualties and the length of the conflict allowed DoD to provide needed care within its own resources. He also said that DoD could have used the 124 facilities in its TriCare network, and that DoD regards TriCare as an extension of DoD whereas VA is not.

One Commissioner asked whether the VA centers designated as critical nodes in the emergency network have been earmarked in the CARES process to ensure they won't be closed. The answer was that they haven't been earmarked. The Commissioner also asked whether emergency disaster centers have been designated yet, to which the answer was that DoD was going to provide a liaison.

Continuing the presentation, Mr. Lambretta next discussed the *National Disaster Medical System*. VA's role in this process is one of leadership and coordination responsibility. This system identifies civilian hospitals that can and will accept casualties in the event of a national disaster. The system includes a total of 75 Federal Coordinating Centers, 43 of which are managed by VA, 32 of which are managed by DoD. In all, VA has memoranda of agreement with 1,346 private hospitals to provide 60,000 beds (DoD has agreements with another 434 hospitals). The system is designed to provide approximately 30,000 beds in 72 hours in response to a disaster.

VA also has emergency support functions under the *Federal Response Plan*, which is the mechanism that coordinates the delivery of Federal resources to State and local governments in the event of a major disaster or emergency. In this area, the Department of Health and Human Services is the lead agency. VA is responsible for providing pharmaceutical support in the form of:

- Pharmacy caches for National Disaster Medical Support/Weapons of Mass Destruction.
- One of twelve 50-ton pharmaceutical pushpiles in the CDC National Pharmaceutical Stockpile.
- The Congressional pharmaceutical cache (which was used during the anthrax attack).
- Numerous VA caches.

For VA, 97 of 143 caches are deployed at major medical centers. A large cache will provide pharmaceuticals to 2,000 patients for two days. VA is reimbursed for its pharmaceutical caches.

Mr. Lambretta also described VA's role in a number of emergency preparedness activities since 9/11. They have included support for the National Guard and Reserve in response to the 9/11 attacks on New York and Washington; support for the anthrax attacks response, and readiness preparations for high-profile events such as the Super Bowl, the Olympics and the anniversary of the 9/11 attacks. Mr. Lambretta said VA is proud of its interagency relationships with such organizations as DoD, the Department of Homeland Security, the Department of Health and Human Services and the American Red Cross.

### Q&A/Discussion

Asked about command and control arrangements for the emergency/disaster programs, Mr. Lambretta said the Department of Homeland Security has the overall lead. Asked how VA would create the number of vacant beds it is committed to supply to DoD if that became necessary, General Claypool acknowledged that it wouldn't be easy to do, but there is a plan for managing such things as elective surgeries that would provide the necessary bed space over a period of 30 days. Mr. Lambretta also agreed to provide the Commission with a list of the primary and secondary receiving centers involved in the DoD contingency support plan.

### **Presentation By S. Anthony McCann Commissioner, President's Task Force To Improve Health Care Delivery for Our Nation's Veterans**

**Mr. McCann** spoke to the CARES Commission about the President's Task Force, which will present its report to the President at the end of May. The Task Force, created in 2001, has 15 members and is co-chaired by Gail Wilensky and former Congressman John Paul Hammerschmidt. Its mission is to identify opportunities to improve the delivery of health care services to both DoD and VA beneficiaries through better coordination.

Mr. McCann said the Task Force's recommendations articulate and update ideas that have been discussed for many years. Two factors are behind the changes: (1) changes in health care delivery, and (2) changes in the VA system—especially pharmacy benefits and the creation of CBOCs—that brought more veterans into the system.

Two of the Task Force's recommendations are expected to have a significant impact on CARES. One addresses the differences in the way the DoD and VA health care systems are funded. With the enactment of TriCare and TriCare for Life, DoD's funding process is much like mandatory funding. VA's budget comes from discretionary funds. This has created a big disparity. It is clear to the Commission that for VA, which still relies on fixed appropriations, demand far

exceeds available funding. The effect on VA health care services has been to limit access for veterans, resulting in long waiting lists. The Task Force will recommend in Chapter 5 that Congress and the Executive Branch find a mechanism to ensure that enrollees in Priority Groups 1 – 7 have full access to timely health care. VA’s current access standards would be used to define “full access.” If VA can’t meet its access standard because its facilities have limited capacity, VA should be required to purchase services from the private sector. The Task Force will also recommend that funding be made available to provide care to Priority 8 veterans. The Task Force expects that its funding recommendations will have a big impact on VA facilities over time. The Task Force believes there is a substantial latent demand for VA health care services, which mandatory funding could address.

The other recommendations from the Task Force that will impact CARES involve barriers to coordination between DoD and VA. The Task Force found that the average age of VA facilities was 63 years and that half of all military facilities are 25-50 years old. These aging, outdated physical plants are expensive and neither Department has an effective planning process to deal with it. Accordingly, the President’s Task Force will recommend:

- Creating a joint database and a joint planning process.
- Joint ventures for new construction.
- A joint VA-DoD Health Executive Council to provide leadership and maintain a long-term focus.
- Developing and deploying a joint medical records system that includes the full record of a veteran’s service life.
- A single separation physical by 2005 to ensure a single process for making the transition from the military to VA.
- A single national formulary, including a single screening tool and the ability for beneficiaries to get prescriptions filled at the most convenient pharmacy, whether DoD or VA.
- Administrative realignments and improvements.

Mr. McCann said the Task Force tried to couch its recommendations in terms of patient-based or beneficiary-based goals. In regard to facilities, the Task Force hopes to achieve a combination of transparency and joint physical facilities between DoD and VA. Joint ventures are being recommended as a way of accomplishing this. Joint ventures are viewed as the exception to the rule now; the Task Force is recommending that they become test beds for new practices and procedures. Any significant new construction should be examined carefully to see if there is a “joint venture answer” that could be adopted.

Mr. McCann promised that the Task Force report will be provided to the Commission as soon as it becomes available.

### Q&A/Discussion

Asked to explain further the mismatch between DoD and VA funding, Mr. McCann said the funding mismatch occurs because DoD’s TriCare program acts like an entitlement program (although it is not one) by giving the system sufficient funding to pay for each beneficiary’s care. VA operates with an annual appropriation, which is often insufficient to cover costs. The appropriation is fixed, not based on how many veterans are receiving services and at what cost. When VA is in a growth mode, as it is now due to increasing enrollment spurred by rising

private sector health insurance and prescription drug costs, the size of the disparity gets bigger every year.

A Commissioner asked about the difference between DoD and VA regarding prescription drug benefits. Specifically, he asked why all Federal beneficiaries couldn't be covered by a single system. A Commissioner observed that DoD and VA could have a single joint pharmacy record (that is one of the Task Force's recommendations), but it would be much more difficult to incorporate private doctors' prescriptions into the system. Mr. McCann said the Task Force didn't attempt to assess what Congress might do with the civilian drug benefit program. Another Commissioner noted that the DoD health care system has two separate missions that cannot be combined: combat medicine and TriCare.

One Commissioner said his experience has been that coordination between DoD and VA occurs in the field but falls apart in Washington. Mr. McCann said the Task Force found there had been some progress, but wants to see additional cooperation. Another Commissioner said local VA and DoD hospitals would like to work together more. A serious deterrent is that TriCare contracts are awarded on a national level. Beneficiaries have no incentive to come to VA except for services they can't obtain from a TriCare provider.

Asked whether the Task Force's funding recommendation would include Medicare, Mr. McCann said the goal was to have an assured payment. He said part of that might come from Medicare.

**Presentation By  
Hari Sastry and Dan Erman  
Program Examiners, Office of Management and Budget**

Mr. Sastry of the VA Health Branch at OMB said the Administration fully supports putting services where the veterans are. It included \$225 million in the budget for new facilities. He stressed that how and where VA health care is to be delivered in the future is very dependent on CARES and the Commission's recommendations. There is a very high level of interest in CARES at OMB that will not diminish. OMB's interest is in enhancing the experience of veterans by funneling the correct types of service to where the veterans are. OMB would also like to see VA realize efficiency gains. He said the Administration is very focused on agencies' making the best use of resources.

OMB's expectations are that the CARES process will address the GAO report and will make services available to veterans where they need it. OMB would also like to see VA be more consistent with the private sector. Among the Commission considerations that OMB is interested in are (1) the public hearings – where they will be and how they will be structured – and (2) how the hearings will examine DoD/VA sharing.

Mr. Sastry said OMB understands that an infusion of funds will be needed to complete the CARES process. In regard to long-term care, OMB is waiting for VA to develop a policy proposal.

## Q&A/Discussion

Asked what OMB means by “moving the funds to where they are needed most,” Mr. Sastry said OMB won’t know the specifics of that until the plans are finalized, but they are already receiving statements to the effect that selected states won’t receive enough funding to meet their needs.

A Commissioner noted that there will be later iterations after this CARES process, to incorporate long-term care into the picture, for example. Noting that these later iterations may have greater budgetary impact than the current process, he asked if OMB would wait for even more studies or would it act. Mr. Erman replied that OMB has been working with VA on a new policy related to long-term care. He stressed that OMB is not waiting for the CARES Commission on this matter; it is waiting for VA to submit a policy proposal.

Noting that \$225 million – the amount included in this year’s budget for facilities – is very small compared to private sector investments, a Commissioner asked if OMB was prepared to support a much larger scale program. Mr. Erman answered affirmatively. He said OMB understands that CARES will be a long-term program requiring funds over a five-to-seven year period. OMB is also aware that there will be money besides CARES required for capital construction, both major and minor (he said the \$225 million is split roughly \$180 million for major and \$45 million for minor projects). He is hopeful that OMB will be able to build up to a critical mass of funding for facilities.

Asked whether OMB is concerned about the political ramifications of the timing of the Commission’s report, Mr. Sastry replied he couldn’t address that.

Noting that CARES has been a convenient excuse for appropriators to defer funding for capital projects, a Commissioner asked what OMB’s role had been in holding off funding pending completion of CARES. Mr. Sastry replied that the House and Senate have used the CARES process as a reason not to provide funding. He said OMB will support whatever is in the President’s budget. Mr. Erman noted that the current budget represents the first time OMB has sent included significant sums for capital projects. Like other key players, OMB is waiting to see how Congress will respond to this request.

Asked whether OMB had examined the relative cost-effectiveness of VA long-term care compared to State programs, Mr. Erman noted that OMB has supported State veterans homes, but hopes to transition from the traditional model to private sector trends, such as assisted living, for example. One Commissioner noted that assisted living provides a cheaper, unregulated venue for providing care.

**Wednesday, May 14, 2003**

### **Hearing Preparation – Strategy & Issues**

During the morning session, the Commission met in breakout sessions as three teams to discuss hearing preparation, strategies and issues.

The Commission is currently waiting to receive the draft National plan from the Under Secretary for Health. Once that occurs, the Commission will hold hearings through mid-August, followed by preparation of its report and recommendations.

The Commission's review of the PIs, which was done in April, was compared to the Commission's review of the market plans. The Planning Initiatives were *data driven*, whereas the market plans will be *criteria driven*. The PIs were reviewed using a scorecard; the market plans will be reviewed using a hearing strategy. The strategy recommended by the staff uses five key criteria to evaluate the plans in terms of seven significant issues. The suggested evaluation criteria, which the Commission will discuss and can change, are:

- Accessibility
- Cost effectiveness
- Mission integrity
- Minimize staff impact
- Minimize community impact.

The significant issues, which are based on the CARES categories, include:

- Inpatient workload/access
- Outpatient workload/access
- Proximity
- Small facility
- Collaboration
- Enhanced use

The tasks associated with this part of the process include conducting reviews of the draft national plan and holding public hearings. The end result will be a public record on which to base recommendations to the Secretary.

During the morning's breakout session, the teams will discuss possible approaches to network-specific issues using the above criteria. The teams will discuss whether the market plans address all significant issues, whether there has been adequate stakeholder input, etc. Teams will then agree on a hearing strategy for each Network that includes a hearing agenda, a tentative list of witnesses and broad issues to be addressed. The Commission will reconvene in plenary session, discuss the approaches agreed to by the three teams and merge the individual results into a uniform hearing approach and strategy. The goal is to build a solid, comprehensive record on which to base decisions.

#### Q&A/Discussion

Asked whether the Commission would be establishing priorities among the criteria and what "evaluating the criteria" means, Mr. Larson indicated that these are exactly the types of questions that the Teams should be addressing in their breakout sessions.

#### **Breakout Sessions**

During the breakout sessions, the staff assigned to support each Commission Team summarized the market plan information they have received from NCPO. The Commission itself has not yet had access to the plans because they are still "pre-decisional." However, the staff has received

some information in the form of VISN-level “mini” market plans, and these provided the basis for the team discussions.

The purpose of the breakout sessions was to begin familiarizing the Commissioners with the substantive content of the market plans and to identify the review strategies that would produce the most consistent, comparable results across hearings for similar market plans in different VISNs. The Teams briefly reviewed each VISN – geography, enrollment, special populations, planning initiatives by CARES category, number of market plans on the table, proposed hearing schedule and dates, etc. The staff members assigned to each team then summarized the matrix approach suggested as a framework for reviewing the plans (comparing issues against criteria). On a VISN-by-VISN basis, staff members summarized the mini market plans that had been submitted for the planning initiatives identified. Commissioners commented on the criteria to be used for review, asked questions about the plans, identified issues that could or should be raised at the hearings, identified additional information needed and discussed the potential makeup of the witness panels for each hearing. Material developed for the different teams was tailored to the work facing that team. A summary of each team’s work was prepared for presentation to the Commission as a whole.

### **Commission Discussion of Hearing Strategies**

Following the individual Team meetings, the Commission reconvened in plenary session to discuss the various approaches suggested, identify common themes and concerns and agree on an overall strategy and approach. A panel was created consisting of three Commissioners, one from each Team. The challenge the Commission faces is that plans for a total of 74 markets will be covered in 38 regional hearings plus one National hearing. Each Team will be involved with only one-third of these. At the end of the process, however, the Commission must reach a cohesive decision, so it’s necessary for each team to be comfortable with the approach the other two will be using.

Comments offered by the Team representatives (Commissioners) included:

- The Commission is not a policy-making body; Commissioners should be in a listening mode during the hearings.
- Adequate preparation will be essential. Commission Teams should know what they are facing *before* each hearing through press clips, issue identification and review of witness testimony.
- Teams should prepare standard lists of questions to be asked of the various panels at each hearing to ensure that the information generated by the various hearings is comparable. Commission staff should identify crosscutting issues.
- Witness panels should always include VISN directors, Congressmen, VSOs and unions. Others are to be invited as appropriate – affiliates, local officials, state veterans directors and DoD. Panels should also be asked about the status of collaborative opportunities. Whether or not to have a panel of local service providers was discussed but remains an unresolved issue. One Commissioner noted that the reason the local VA units were asked to help organize the hearings was to ensure that appropriate witnesses wouldn’t be overlooked.
- One Team asked to have a brief description prepared in advance for VISNs that have already gone through mission changes specifying what criteria were used.

- Teams should determine the extent to which VISN planners considered enhanced use leases as an alternative to new construction, relocation or closure. Enhanced use leases appear to be appropriate as a solution to long-term care and homeless veteran needs. Several Commissioners said they would like more information about enhanced use leases. One noted that the current process is slow and bureaucratic. Another said there is a proposal before Congress to improve the process, but it isn't clear whether it will be approved.

**Stakeholder Presentation By  
Dr. Miklos Losonczy, MD, PhD, Co-Chair,  
VHA Severely Chronically Mentally Ill (SCMI) Committee  
Mr. Ralph Ibson, Executive Director, National Mental Health Association**

**Mental Health Issues and CARES**

**Dr. Losonczy** said Congress established the SCMI Committee through the Veterans Eligibility Reform Act of 1996 to advise the Under Secretary for Health. The Committee evaluates the quality of care provided to VA mental health patients and improvement opportunities. It provides an annual report to the Under Secretary and also comments on the annual "VHA Capacity Report." The Committee has 14 members, plus a wide range of consultants, experts and advisors. It meets regularly and invites the top leadership of VHA and key VSO groups to its meetings.

Dr. Losonczy told the Commission that the SCMI Committee strongly supported VA's change from inpatient based mental health services to comprehensive recovery-oriented outpatient services. He said the transformation has successfully decreased the number of inpatient beds since 1996 but has been only moderately successful at improving recovery-based care.

Recovery based care seeks to provide services that will enable veterans with serious mental illness to achieve their highest possible level of functioning. Services include the intensive case management needed to improve social skills, family support, work restoration, housing autonomy, psychoeducation and other skills.

The Committee has noted substantial, and striking, variability in access and capacity for mental health services from Network to Network. VA needs population-based standards for what services should be offered at what capacity. Dr. Losonczy noted that recovery-based care services are also uneven *outside* of VA. The Committee believes that mental health care should be available at all but the smallest CBOCs.

The Committee's main recommendation for the past three years has been to establish a national mental health strategic plan based on a population-based needs assessment. The plan should include recovery-based services. VA has said the CARES process would provide the vehicle for developing the strategic plan.

The SCMI Committee was not involved in CARES planning until September 2002 except for commenting on the VISN 12 pilot. At that time, the SCMI Committee had its initial exposure to

the major features of the model and how it would be used. The Committee determined that the CARES model is not the right model to use for mental health. Deficiencies include:

- Data based on a private sector population that is less ill than VA patients.
- The Milliman model had caps on both inpatient and outpatient services.
- The model is not recovery-oriented.

Dr. Losonczy noted that the severely mentally ill population in VA more closely resembles the public sector mental health population than the private sector population, but public sector mental health data were not available to the contractor.

Other concerns about the Milliman model included the fact that some VA services have no private sector equivalent. These include domiciliary care, long-term mental health care, residential services, day treatment, methadone treatment, and compensated work therapy. It is also unclear whether the private sector has significant intensive case management. These concerns add to the inappropriateness of using private sector data as the basis for the VA model for mental health.

Moreover, the model assumes that the rate of service utilization in the future will be the same as that of the relatively short baseline period (10/98 through 12/01) for any given age/sex/priority level cohort. The model predicts that the over-65 population will barely use mental health services. The Committee doesn't believe this is true for VA patients. For World War II veterans, the stigma associated with mental illness may have prevented many from seeking services. But the younger veteran population, especially Vietnam veterans, has a totally different view of mental health services. Consequently, the Committee believes that there is a substantial patient population base for mental health services.

Because of its shortcomings, the model shows mental health demand decreasing while enrollment increases. It also projects mental health outpatient demand as being much lower than the primary care and specialty care projections. Recognizing that this part of the model should be closely examined, the CARES office removed all "negative" mental health outpatient PIs (i.e., those PIs that projected decreasing demand) from the CARES process pending further review of the model. The Committee asked to have *all* mental health PIs removed from the process.

On a national level, the data showed little or no relationship between new primary care utilization projections and mental health projections. There are even areas with large increases projected in primary care that show large decreases in projected mental health demand, despite the fact that historical experience indicates that 20 percent of primary care patients have mental health needs.

Other service areas, such as domiciliary care, were also removed from consideration because of model deficiencies, but CARES developed inpatient mental health PIs despite reservations about the model. For inpatient services (acute psych, substance abuse and long-term psych), the model combined demand for all specialties into a single number, producing skewed results. The model is also producing results that are not understandable for actual-to-expected ratios and the "reliance" adjustment is at the VISN level, which is one level too high.

The CARES Office agrees that improvements are needed, and corrections are currently being made. Some of the improvements include:

- Using VA data instead of private data.

- Linking increases in primary care utilization to mental health utilization.
- Establishing realistic expectations regarding mental health utilization for older veterans.
- Using published data as a basis for projecting utilization rates for veterans with substance abuse treatment needs.

Completing this work is urgent. Current data and projections are in use throughout the VA, even though they have deficiencies. Further, next year's strategic planning process will use the CARES projections. The time available to complete the work of improving the CARES mental health model is very short – only a few months.

**Mr. Ibson** said his organization, the National Mental Health Association, advocates the position taken by other VSOs in this year's Independent Budget for VA, that is, deferring CARES implementation until VA validates a planning model for inpatient and outpatient mental health care. A primary reason for this view is that the model is flawed. It projects future need from a constrained baseline of mental health care utilization rates where even small errors can have large implications. His organization doesn't believe that a flawed planning model should be rushed into implementation.

Mental health care is particularly critical to VA, and CARES will underestimate the need for it. Mr. Ibson said that mental health is one of the core specialized care programs that sets VA apart as a vital resource.

VA's "safety net" mission is especially important to veterans with mental illness or substance use disorders because they lack other options, even if they have other health care coverage. Medicare requires a 50 percent co-payment for outpatient mental health services and has a lifetime cap on psychiatric hospitalization. Private insurance plans offer notoriously poor benefits for mental health care, and employer-provided health insurance places stricter limits on mental health care than on other types of medical care. The only other alternative is the overburdened, under-funded public mental health system that has been characterized as "in a shambles." Because of this situation, veterans with mental illness have relied heavily on VA for care. More than 50 percent of veterans service-connected for a psychosis and more than 60 percent of veterans service-connected for PTSD used VA health care services in 2000.

Addressing how to predict veterans' future needs for mental health services, Mr. Ibson said his view is that neither current system wide utilization data nor private sector data are a reasonable baseline for gauging future need.

Mr. Ibson said that Congress has acknowledged through numerous statutes the special obligation VA has to veterans with mental health problems. In 1996, when the VA health care system was reformed, Congress foresaw the danger of cost-cutting inherent in a decentralized system. It expressed concern about the future viability of costly specialized treatment programs, including mental health services, and took steps to ensure that VA would not transform itself into a "national HMO." At that time, it enacted statutory language to protect the specialized programs, requiring VA to maintain its then-existing specialized treatment capacity for veterans with mental illness and other specified conditions.

Mr. Ibson said VA has failed to comply substantially with the requirement to maintain that capacity, instead closing inpatient facilities and failing to replace them with community-based programs. The SMI Committee's annual reports have documented the failure and the

Independent Budget for '04 highlights it. More specifically, he noted that while VA's medical care appropriations were increasing by 30 percent, 18 Networks showed a decline in inflation-adjusted dollars for care of serious mental illness and 20 Networks showed a decline in substance use care, treating 15 percent fewer patients.

Veterans should be able to expect relative equity of access across the VA system, but VA data show wide variability from network to network in the mental health services available to veterans (for example, a 400 percent variability across VISNs in inpatient psychiatric beds per 10,000 patients). There are no standards. Most CBOCs still do not provide mental health services, and a performance measure aimed at achieving this goal was dropped. For these reasons alone, the Commission should not rely on the amount of care provided in 2001 as a basis for projecting future need.

Private sector data sources are not a reliable basis for determining VA's future need for mental health services. Mental health care is arbitrarily constrained under Medicare and private insurance, so they can't be relied upon to determine *need*.

If VA is to continue to be a viable health care system in 20 years, it must meet today's standard for state-of-the-art care. Today's VA mental health care falls far short of the state-of-the-art. Both the Surgeon General and the President's Commission on Mental Health recognize recovery as a realizable goal for people with mental illness. Recovery-oriented care requires an array of services, including intensive case management, access to substance abuse treatment, peer support and psychological rehabilitation (including housing, employment services and independent living and social skills training).

Recovery-based care should be the norm for VA programs, but it is not. As an example, Mr. Ibson noted that less than one percent of the 82,000 veterans with psychosis who are age 50 or less participate in VA's Compensated Work Therapy (CWT) program, an effort to foster re-entry into the community.

In conclusion, Mr. Ibson urged the Commission to help VA "get it right" and (1) not allow inadequate and unvalidated data to drive the decisions, and (2) not allow artificial timelines to dictate its advice.

### Q&A/Discussion

In response to Commission questions about how it should deal with the short time frame for review and decision making, Dr. Losonczy recommended that the Commission ensure that CARES doesn't massively underestimate need, recommend a better process to the Secretary and recommend that local VA units not use the flawed data for long-term planning. He suggested requiring all data to be labeled, "Please use with care."

Asked about the law on special populations capacity, Mr. Ibson said there has been ongoing disagreements between Congress and the Department about that. Dr. Losonczy added that inflation should also be taken into account. The *effective* spending for mental health is much less now than it was in 1996, and full-time equivalent positions (FTE) have declined by 22 percent.

A Commissioner asked about primary care projections increasing while mental health projections were not. Specifically, he asked whether VA was capturing the data. Dr. Losonczy

said VA is capturing the data, but he doesn't have a high level of confidence in the ability of primary care physicians to treat mental health. Psychiatrists should be available everywhere, not just at large primary care facilities.

Dr. Losonczy agreed to provide copies of the SCMI Committee's annual reports to the Commission.

Asked whether local mental health affiliates have been involved in CARES planning, both presenters said they didn't believe so.

**Presentation on GAO Perspectives**  
**Paul Reynolds, Assistant Director for Health Care, General Accounting Office**  
**Michael Blair, General Accounting Office**  
**Cindy Bascetta, General Accounting Office**

**Mr. Reynolds'** presentation summarized GAO's role to date in the CARES process, outlined GAO's plans for analyzing the CARES market plans and addressed the Commission's areas of interest. Throughout, he emphasized that GAO wants to work cooperatively with the Commission on CARES plans.

Mr. Reynolds told the Commission that GAO has been involved with CARES since its inception in VISN 12. He said GAO has been supportive of VA's efforts to transform its health care system, has reported and testified on the progress of VA's efforts to transform itself from a hospital-based system to an integrated network of health care providers, and has often suggested ways to improve VA's operating systems and veterans' access to health care.

Several years ago, GAO identified VA's large, aged infrastructure as a barrier to the transformation that VA hoped to make. During the VISN 12 pilot, GAO testified that a more disciplined process was needed. GAO now believes that VA deserves credit for re-designing the CARES process in a way that could significantly improve the delivery of health care to veterans, although realizing this end will require bold and courageous decisions in a relatively short time period. It also believes that VA selected the right areas of concern – access, small facilities, proximity and workload demand shifts. GAO was especially interested in VA's ability to find money to re-invest by looking at facilities in "mega-markets," where facilities or services could be consolidated.

Mr. Reynolds also identified several principles that have guided and would continue to guide the GAO's approach to analyzing market plans. These include:

- Consistent treatment of similarly situated veterans (as a matter of equity),
- Consistent treatment of similarly-situated facilities, such as small facilities (also a matter of equity), and
- Maximizing service enhancements for veterans (as a matter of efficiency).

In analyzing the CARES market plans, Mr. Reynolds said GAO's concerns include all similarly situated geographic areas (i.e., with concentrations of veterans) or facilities *regardless of whether they have been identified by CARES as Planning Initiatives*. GAO will look at *access proposals first* because those solutions may influence other areas of concern. He noted that

GAO is aware that using the wrong workload can lead to the wrong decision. GAO will also examine whether consistent decisions are reached for similarly situated geographic areas and facilities. A three-tiered process is contemplated:

- Review at the market level,
- Review of VISN groups, and
- Grouping similar situations for review.

Mr. Reynolds said GAO is worried about the large amount of discretion built into the process and will try to determine its effect.

The focus of GAO's review of access proposals will be on markets where VA identified PIs for primary, acute and tertiary care. GAO will also examine travel times for enrolled veterans who live outside VA's access standards in markets where there are no PIs, focusing on areas with concentrations of veterans comparable in size to markets *with* planning initiatives. In these cases, GAO will be review apparent anomalies such as these:

- Of the 1.8 million enrolled veterans who live outside VA's acute inpatient care access standards, over 880,000 veterans aren't included in the scope of VA's access PIs (920,000 are included).
- GAO has tentatively identified 44 geographic areas with large concentrations of enrolled veterans (10,000 or more) who are outside VA's access standards. Of these, 26 areas are included in the planning initiatives. However, 18 areas are not included in Planning Initiatives, and GAO will want to know how their care will be addressed and whether it will be comparable.

GAO will also focus on *outpatient specialty care*, where there were no access standards or access planning initiatives. GAO was disappointed by this, noting that even though some veterans face long (4-5 hour) drives for a 20-minute appointment, including them as PIs was completely discretionary. Mr. Reynolds also said GAO thinks that VA's access standards for acute inpatient care would be reasonable for measuring access to specialty outpatient care. For example, the 1.8 million veterans noted above who live outside the access standard for acute inpatient care may also have to travel long distances for outpatient specialty care.

Regarding *small facilities*, GAO's analytical approach will focus on the 19 facilities that VA identified for PIs as well as on the four small facilities that VA added because of small bed sections (particularly for surgery). GAO identified an additional nine facilities that had less than 40 beds in 2022 but not in 2012.

In analyzing tertiary facilities for *proximity*, GAO will concentrate on the 21 pairs of facilities that VA identified for PIs. However, GAO has also identified for analysis an additional 17 pairs of facilities that are within the 120-mile standard that were not selected for PIs. Similarly, GAO will look at the 11 pairs of acute facilities selected for proximity PIs, plus 19 pairs that are within 60 miles of each other that were not selected.

For *workload*, GAO will review all of VA's Planning Initiatives, which involve 187 geographic areas, plus an additional 18 areas that did not meet VA's criteria. GAO has also tentatively earmarked for analysis 40 additional areas that met the VA workload criteria but which were not selected for PIs.

Mr. Reynolds said GAO is quite concerned that a significant portion of VA's inpatient workload demand is not included in the CARES planning initiatives -- nursing home and long-term psychiatry beds. Also, when GAO looked at some small facilities, they discovered that they were not "small."

GAO will also analyze the plans for resource concerns, such as the recurring costs to operate and maintain capital investments and efficiency savings that might be available for reinvestment. GAO is looking for a balanced approach and is concerned about both "over promising" and "under enhancing."

Finally, Mr. Reynolds said GAO has concerns about the validity of the data, including the lack of documentation, the use of a constant rate for projecting enrollment and the large variance between the 2001 projections and actual experience.

### Q&A/Discussion

In response to a question about whether GAO had any specific findings it can share with the Commission, Mr. Reynolds said that GAO has performed a number of analyses that it would share with the Commission. He noted that they, like the Commission, will be reviewing the market plans over the summer.

When asked to elaborate on the difference between 2001 projections and 2001 actual utilization, Mr. Reynolds said he didn't have the details with him, but would provide them to the Commission.

Asked whether GAO would be comparing VA's outpatient specialty care to private sector specialty care, Mr. Reynolds said it would be doing that kind of analysis to determine whether treatment is consistent and if not, why not.

One Commissioner, noting GAO's extensive work in long-term care, asked whether GAO could share its views with the Commission. Ms. Bascetta said GAO's concerns with long-term care mirror those just presented for mental health: data projections that don't make sense and variability in the services provided across networks. GAO doesn't yet understand why the projections don't work. She also noted that some Networks have put their own eligibility criteria in place, indicating the lack of a clear, consistent policy.

Mr. Reynolds answered another question by saying GAO would be willing to share information with the Commission about the situations they are analyzing that met the CARES criteria but for which no PIs were established.

Regarding the concerns about variability across Networks and discretionary decision making, Mr. Reynolds said it's okay to have discretion; GAO just wants to determine what the VISNs are doing and why. He also noted that definitions are a serious problem in VA, and said it's a matter that should be raised at the hearings. As an example, he said different VISNs use different definitions for "nursing home."

In response to a question about the role of state veterans homes, which are totally outside of the VISNs, Mr. Reynolds said GAO would also be reviewing that issue as well.

In closing, Mr. Blair noted that, contrary to some of the statements made to the Commission, GAO has never reviewed the Milliman model.

**Presentation on Enhanced Use Leasing**  
**Jim Sullivan, Office of Asset Enterprise Management**

In response to the Commission's request for additional information about the enhanced use leasing program, Mr. Jim Sullivan outlined the program for the Commission. The program, which is Congressionally authorized, allows VA to lease its land and facilities for up to 75 years for both VA and non-VA uses. Leases may involve either cash or "in kind" considerations. Funds received in excess of expenses go into the Medical Care Collections Fund. To date, 27 projects have been undertaken in 12 years, five of which have involved bond financing. Over 100 initiatives have been studied, and 23 of these are on the Secretary's priority list. The enhanced use process is complex, but the biggest delay so far has been CARES.

Mr. Sullivan detailed the advantages and benefits of the program from the perspectives of the various stakeholders. From VA's perspective, the benefits include:

- Maximizing the return on unused land and facilities while retaining them for future needs.
- Reducing or eliminating facility development costs.
- Using private money instead of VA appropriations.
- Creating win/win situations for local communities.
- Serving as a platform for "enhanced sharing agreements" (which are different).
- Generating cash to meet local needs.
- Possibly accelerating implementation schedules.

The benefits from the private sector's perspective are:

- Providing the property interest necessary to secure financing.
- Providing access to VA and to local market opportunities.
- Using local codes and standards.
- Generating opportunities to buy or sell services through piggybacked sharing agreements.
- Generating tax revenue (the improvements are taxable; the land is not) and creating local jobs.
- Potential purchase at a later date.

Mr. Sullivan said Congress has indicated that enhanced use authority should be used more. It expanded the authority expecting it would be used to generate revenue and improve services to veterans. OMB's concerns have been assuring an adequate return to VA, a reasonable return to the lessee and a fair comparison with other alternatives. Mr. Sullivan said how to "score" long-term commitments under the Budget Act has been a considerable barrier to using the authority.

Mr. Sullivan described the types of opportunities that are available using the enhanced use program. The list includes: VA office collocations, energy facilities, skilled nursing facilities and assisted living centers, temporary housing, consolidations, medical and medical research facilities, parking garages, child development and day care centers and golf courses and other recreational opportunities. CARES-generated opportunities could also be implemented using enhanced leasing authority.

The complex, and potentially lengthy, process includes several special requirements:

- Project-specific concept plans (the vehicle for securing Departmental approval).
- Public hearings at the local site (to obtain VSO and community input).
- Special selection procedures to ensure process integrity.
- Two Congressional notifications.
- A review by OMB of “significant” projects (which can be a lengthy process).

Enhanced use opportunity analysis was a part of CARES. Projects with high potential, described on the web site ([http://vaww.va.gov/budget/capital/eu/CARES\\_High\\_Potential.asp](http://vaww.va.gov/budget/capital/eu/CARES_High_Potential.asp)), provided a top-down perspective on enhanced use, identified real estate resources in high-value locations (discussed separately) and provided VISNs with a first look at market-driven opportunities. The analysis was based on the current use of VA facilities and land and described “feasible” concepts. The opportunities identified do not address mission or programmatic needs.

A valuation analysis was used to generate a list of the top 20 projects and to provide an “order of magnitude” estimate of the opportunities available. The valuation facilitates comparisons for CARES analysis within and across VISNs. It includes both VA and non-VA perspectives on values. The list looked only at properties currently available based on current use, not on realignment. Historic and environmental constraints and specific redevelopment issues are not factored into the valuation estimate. The valuation analysis also has a web site: ([http://vaww.va.gov/budget/capital/eu/CARES\\_Valuation.asp](http://vaww.va.gov/budget/capital/eu/CARES_Valuation.asp)).

The implementation issues associated with enhanced use leasing include: insufficient capacity, a lack of programmatic policies (such as for VA’s fourth mission), uncertainty resulting from OMB requirements, market research tools, the review process, and Congressional notification. Mr. Sullivan discussed several things VA is doing to deal with these issues. They include adding portfolio managers, obtaining additional contract support (for market valuation and concept planning), designating capital asset managers in the VISNs, bundling projects and negotiating with OMB and proposing legislation to streamline the process.

Flow charts were presented comparing the current process to a proposed new process (currently pending Congressional authorization). The new process, designed to reduce the time and bureaucratic steps required to engage in enhanced leasing, would eliminate several current steps and change the timing of others.

Several “success stories” were presented as examples of the types of projects that can be done under the enhanced use authority. These included a health care facility lease in Indianapolis, a regional office collocation, a mixed-use development in Houston and a homeless facility in Vancouver. Several other projects, now in the developmental stage, were also outlined.

### Q&A/Discussion

A Commissioner said he is aware of dozens of other initiatives where this type of project was attempted without producing any money. The VA rep said only three have failed, several have been successful and more are in the pipeline.

**Presentation on Critical Access Hospitals (CAH)**  
**Dr. Barbara Chang, NCPO**

Dr. Chang acknowledged that the draft National plan may propose that some hospitals receive a designation as a “critical access-like” facilities as part of the small facility review. The details of the concept are still under consideration by the Under Secretary, but will be included in the draft National plan.

VA will propose its own criteria for the designation, but it will involve only medicine beds and facilities with fewer than 40 acute care beds. Nineteen facilities were reviewed for this designation by NCPO teams and the Clinical CARES Advisory Group.

Critical access hospitals are an offshoot of an earlier Federal program for non-governmental rural hospitals. These facilities are exempt from the Medicare payment system and are paid on a cost basis. There are 762 critical access hospitals nationwide and the number is growing rapidly. Medicare has used the designation since 1999. Their criteria include:

- Being more than 25 miles from the nearest hospital.
- State designation as a necessary provider.
- No more than 15 acute care beds.
- The requirement to be part of a network of hospitals.
- A length of stay of not over six days.

Some VA facilities are already functioning in a CAH-like capacity.

CARES reviewed 19 facilities for potential designation as a CAH-like facility. The purpose of the designation would be to keep hospitals located in very rural areas open. It would also help to improve the quality of care offered at these facilities. The review included an evaluation of where these facilities fit into the Networks’ plans and an examination of the alternatives available. Teams from the CARES staff and the Clinical CARES Advisory Group conducted the review. Dr. Chang said the review raised a number of issues, including both policy and transportation issues. The specific details of the proposals are not yet available because they are undergoing review by the Under Secretary.

Q&A/Discussion

Asked about the impact on CARES PIs, Dr. Chang said that would be included in the draft plan, but VA will recommend eliminating intensive care beds in some small facilities. The small facilities doing the best job are the ones doing the least complicated things.

Asked how many facilities are likely to be included in this effort, Dr. Chang said about eight. The goal would be to recognize the important role these facilities play in their communities and improve their performance, functioning and efficiency.

## **Sensitivity Analysis**

Chairman Alvarez announced that he wants the staff to start the process of conducting sensitivity analysis on the demand model and to keep the Commission apprised of the results. There was no objection.