

Statement of
The Honorable Anthony J. Principi
Secretary of Veterans Affairs
Before The
Subcommittee on Health
Committee on Veterans' Affairs
United States House of Representatives

June 24, 2004

Mr. Chairman and Members of the Subcommittee:

Thank you for providing the Department of Veterans Affairs (VA) this opportunity to discuss my recent decisions surrounding the Capital Asset Realignment for Enhanced Services (CARES) and the draft of a proposed bill to be entitled, "The Department of Veterans Affairs Real Property and Facilities Improvement Act of 2004." The bill contains several provisions that would significantly enhance VA's ability to manage and expand its capital resources while promoting efficiencies, and cost savings. Most importantly, the bill would facilitate the implementation of CARES. I request an opportunity to more closely review the specific provisions of the bill and supply the results of our review for the record.

As you know, last month I announced my decision on the future of VHA's capital infrastructure and publicly released my CARES Decision Document, copies of which have been provided to the Committee. It is not my intention today to discuss the details of the entire decision document. Instead, I will focus my discussion on the following issues of particular interest to the Committee:

1. The CARES Implementation Board;
2. Community Based Outpatient Clinics;

3. Mental Health Strategic Plan;
4. Long-term Care Strategic Plan;
5. Veterans Rural Access Hospital;
6. Special Disability Program for Spinal Cord Injury and Disorders;
7. Capital Initiatives for the Veterans Health Administration; and
8. VA/DoD Sharing Opportunities

Before I address those topics, however, I would like to provide a brief background on CARES.

Background

CARES is a data-driven planning process designed to project future demand for health care services, compare projected demand against current supply, and identify the capital requirements and asset realignments VA needs to meet future demand for services, improve access to and quality of services, and improve the cost effectiveness of VA's health-care system. The CARES process is a comprehensive, system-wide approach to projecting into the future the appropriate function, size and location of VA facilities. CARES was initiated to provide a plan for management of VA's capital infrastructure into the future that can be improved over time. For that reason, the tools and a process used to develop CARES will be integrated into annual capital and strategic planning cycles, ensuring continued and systematic planning for the capital resources VA needs to provide quality health care to veterans.

On February 12 of this year, the CARES Commission presented its final report to me. Following an intensive review of this report, I issued my "CARES Decision" on May 7, 2004. In that decision, I formally accepted the CARES Commission's recommendations using the flexibility the Commission provided to minimize the effect of any campus or service realignment on continuity of care to veterans currently receiving services. My Decision and the CARES Commission Report form the blueprint that will effectively guide the Department as it moves

forward to enhance and improve health-care delivery to veterans by modernizing and more effectively managing its capital infrastructure.

CARES Implementation Board

To oversee the many and varied actions needed to carry out my CARES Decision, I established the CARES Implementation Board, which I will personally chair. The Board will provide Departmental oversight of CARES implementation and advise me on CARES-related decisions. The Board is an intra-Departmental, senior-level group and will ensure that implementation actions are consistent with my CARES Decision, meet the Decision's aggressive timeframes, and honor the personal and public commitments made during the CARES process.

The Board will actively participate in developing the methodologies and structure of CARES reviews and studies as called for in my Decision. All CARES decisions will be presented to the Board for my approval, unless approved by me for delegation. Recently the Board held its first meeting and reviewed options regarding the composition and membership of committees, task forces and other groups that will be established to conduct the various studies outlined in my CARES Decision. I expect that guidance will be finalized for my approval in the near future so that these groups may begin their studies and reviews.

Community-Based Outpatient Clinics (CBOCs)

VA is committed to continuing its efforts to meet national standards for access to care for our Nation's veterans by establishing new sites of care through CBOCs. VA will also continue to explore opportunities to improve management of existing CBOCs through more effective staffing, expanding hours of operation, and examining opportunities to augment services where appropriate.

To ensure that VA fulfills its commitment, I established priority criteria for the development of new CBOCs through the CARES process. The priority criteria include the development of CBOCs that:

1. are in markets with large numbers of enrollees, are outside of access guidelines, and are below VA national standards for primary care access;
2. are in markets that are classified as rural or highly rural and are below VA national standards for primary care access;
3. take advantage of VA/DoD sharing opportunities;
4. are associated with the realignment of a major facility; and
5. are required to address the workload in existing overcrowded facilities.

These criteria reflect my determination to produce more equitable access to VA services across the country, particularly in rural and highly rural areas where there are often limited health care options. They also reflect VA's ongoing commitment to strengthening sharing opportunities with the Department of Defense.

My Decision identifies 156 priority CBOCs. These priority CBOCs are targeted for implementation by 2012 pending availability of resources, validation with the most current data available, and approval through the National CBOC Approval Process and the CARES Implementation Board. As VA proceeds in implementing CARES and engages in future planning, the locations of these CBOCs may change, but the priorities will remain constant.

Planning the implementation of new CBOCs has begun. On May 13, 2004, a revised VA Handbook on Planning and Activation of CBOCs was issued to all VISNs. At the same time, VISNs were provided guidance on submission of new CBOC business plans. VISNs are now in the process of preparing business plans for priority CBOCs identified in my Decision that are planned for activation in FY 2004. Additionally, VISNs are preparing business plans for priority CBOCs planned for FY 2005 that require immediate review in order to proceed with

VA/DoD agreements and leasing or contracting obligations. These business plans are to be completed and submitted to the Acting Under Secretary for Health by the end of this month. A review panel will evaluate the business plans, score the applications and develop a recommendation that the Acting Under Secretary for Health will submit to me for approval.

VISNs also received guidance regarding establishing outreach clinics to an existing primary care site, changing the location of an existing CBOC, leasing additional space for an existing CBOC, expanding services at an existing CBOC and changing management models at CBOCs, such as VA-staffed or contract. To obtain approval for any of these changes to CBOCs, the VISNs must submit a justification for the change and a summary of stakeholder comments. In the case of establishing an outreach clinic subordinate to an existing primary care site, approval will be granted only for areas that meet the distance criteria for highly rural areas specified in the national planning criteria.

I should point out that although I established priority criteria and identified 156 priority CBOCs that meet these criteria, these priorities do not prohibit the VISNs from pursuing other CBOC opportunities. VISNs may submit business plans for establishing CBOCs earlier than originally indicated in my Decision or for establishing CBOCs not referenced in my Decision. In either scenario, however, the VISN must demonstrate that it will, at the same time, be able to open any priority CBOC on schedule.

Mr. Chairman, I recognize that resources are not available to open all of the priority clinics immediately. I will work closely with Congress for approval of appropriations to enhance access to VA health care services as well as expand the types of services offered in outpatient sites, particularly specialty care such as mental health services. Moreover, VA will manage implementation of CBOCs by applying the revised CBOC criteria within the existing National CBOC Approval Process and through the authority of the CARES Implementation

Board. This will ensure a careful and considered implementation that mandates VISNs develop sound business plans and ensures that national criteria are met and that resources are available to provide the high quality of care veterans expect from VA.

Mental Health Strategic Plan

VA is committed to meeting the mental health needs of our Nation's veterans, and it is critical that VA's health care system consistently provides comprehensive mental health care services at a high level of quality across the country. Effective mental health treatment requires that veterans have appropriate access to a full continuum of mental health care services.

In my Decision I called for a comprehensive VA Mental Health Strategic Plan. This strategic plan, which is nearing completion, incorporates the recommendations of the report of the President's New Freedom Commission on Transforming Mental Health Care in America through VA's Action Agenda for Transforming Mental Health Care in VA. The recommendations resulting from the VA Mental Health Strategic Plan will require every VISN to develop mental health market plans that incorporate revised projections, which must include projected demand for outpatient mental health services and acute psychiatric inpatient care. Additionally, policies developed in the Mental Health Strategic Plan, such as special emphasis on integrating strategies to meet the future geropsych needs of the enrolled veteran population and incorporating the findings VHA's Work Group reviewing the President's New Freedom Commission on Mental Health Report, will be incorporated in the VISN's plans to ensure that comprehensive mental health services are included in CBOCs; that veterans have access to a full continuum of mental health care services, which are consistent across all VISNs; and ensure acute inpatient mental health services are collated with other inpatient services. I expect to receive the Mental Health Strategic Plan later this summer.

Long-term Care Strategic Plan

Mr. Chairman, many stakeholders have expressed concerns about how VA intends to address the provision of long-term care within the context of CARES. In order to respond to these concerns, I directed in my Decision that VHA develop a Long-term Care Strategic Plan addressing

- consistent access for nursing home care;
- geropsych needs;
- domiciliary care;
- long-term psychiatric care for the seriously mentally ill;
- expanding care coordination in the home;
- residential care, assisted living facilities; and
- other less restrictive care settings.

I am currently considering various policy options that have been designed to adhere to certain core principles, which include a policy that is clinically sound, is fair for veterans, can be modeled for VISN planning, and is acceptable to Congress. Some of the key elements that I will strongly consider are the extent to which the Long-term Care Strategic Plan:

- focuses on veterans who need care for a short duration, for services to restore function following a period of hospitalization, for example, patients who have had a heart attack, stroke or hip replacement; veterans in need of respite care, and geriatric evaluation and management to stabilize medically complex patients; or end-of-life, hospice and palliative care for those who are terminally ill; and
- focuses on veterans who can no longer be maintained safely in home and community-based settings such as elderly patients needing help with activities of daily living, or who require long-term maintenance care and specialized services not generally available in the community, such as chronically mentally ill patients, spinal cord injury or traumatic brain injury patients, and ventilator dependent patients.

The Long-term Care Strategic Plan will be designed to improve the veteran's quality of life by seeking to preserve personal dignity, enhance emotional well being, and provide care in the least restrictive setting possible.

In addition to long-term nursing home care, VA is reviewing its long term-care policy in other key program areas, such as domiciliary and residential rehabilitation programs. VA's long-term care policies relating to these programs will assure that programs in domiciliary structures are focused on residential rehabilitation and that each patient has a clinical treatment plan. As each program (e.g., mental health, substance abuse, and long-term care) defines its discrete capacity for residential rehabilitation, VA will have a more complete picture of the total capacity requirement for domiciliaries.

I will, of course, keep Congress informed of the Long-term Care Strategic Plan once adopted. Once again, in all cases, the Long-term Care Strategic Plan will be designed to improve the veteran's quality of life by seeking to preserve personal dignity, enhance emotional well being, and provide care in the least restrictive setting possible.

Veterans Rural Access Hospital

VA is also reviewing the "critical access hospital" concept that was initially introduced to help ensure the quality of the care that veterans receive at VA's small facilities. Recognizing that some small and rural facilities will be unable to maintain the workload necessary to perform certain surgical procedures or manage some complex illnesses effectively, VA will establish parameters to ensure high quality patient care. A new policy, Veterans Rural Access Hospital (VRAH), is under development and will specifically define the clinical and operational characteristics of small and rural facilities within VA. I have directed that the VRAH policy be completed later this month. In the interim, the missions of small facilities recommended for change will not be altered. Once the new VRAH policy is approved, however, VA will study the scope of services

performed at VA's small and rural facilities using the policy's criteria and the guidance that will be provided. I anticipate the outcome of this study will be clarification of the type and complexity of surgical procedures that can be safely accomplished in small and rural facilities.

Special Disability Program for Spinal Cord Injury and Disorders (SCI&D)

I recommitted VA to excellence in care for veterans with SCI&D by approving new SCI&D Centers in Syracuse, Denver, Minneapolis, and VISN 16, and a certified SCI&D outpatient clinic in Philadelphia. I also approved expansion of existing SCI&D Centers in Memphis, Cleveland, Augusta, and Long Beach. As part of the implementation process for the new centers and the expansion of existing centers, I requested that VHA validate the number of SCI&D beds to ensure the appropriate need for and distribution between acute and long-term SCI&D beds. I also requested that VHA validate the expansion of the existing SCI&D Center or development of a new SCI&D Center in South Florida.

In preparation for implementation of the new and expanded SCI&D Centers, members of VHA's SCI&D Strategic Health Care Group have reviewed and validated SCI&D beds. A balance has been achieved between acute and long-term care planning based on dual, actuarial, demand-forecasting models that have been peer-reviewed, scrutinized, and vetted. The "*CARES Major Construction Projects FY 2004-2010*" appropriately includes plans for expansion of the existing SCI&D Center in Tampa. The new VISN 16 SCI&D Center needs inclusion in the "*CARES Major Construction Projects FY 2004-2010*". Ongoing planning for long-term care outside the SCI&D Centers will be refined after publication of VA's Long-Term Care Strategic Plan.

Capital Initiatives

I am pleased to announce that VA has developed a long-term Capital Plan, which will be delivered to members of Congress shortly. With more than

5,500 buildings and approximately 32,000 acres of land nation-wide, it is critical that VA have a systematic and comprehensive framework for managing its portfolio of capital assets. This plan provides that framework and is a sound blueprint for effective management of the Department's capital investments that will lead to improved resource use and more effective health care and benefits delivery for our Nation's veterans.

As we strive to meet the many challenges that lie ahead, this plan will act as our guide. I recently announced my decisions on the Capital Asset Realignment for Enhanced Services (CARES) process. CARES is the most comprehensive analysis of VA's health-care infrastructure that has ever been conducted and my decision provides a 20-year blueprint for the critical modernization and realignment of VA's health care system. Consistent with my decision, the capital plan outlines CARES implementation and identifies priority projects that will improve both the environment of care at, and expand access to, VA medical facilities and ensure more effective operations by redirecting resources from maintenance of vacant and underused buildings and reinvesting them in veterans' health care. Implementation of CARES will require substantial investment. While I will assess what amounts should be funded in future budgets, this plan reflects a need for additional investments of approximately \$1 billion per year for the next 5 years to modernize VA's medical infrastructure and enhance veterans' access to care.

The capital plan also identifies our highest priority needs for new construction and expansion of cemeteries in areas where burial sites will soon be depleted, new benefits administration office facilities, and information technology projects designed to improve customer service and enhance delivery of VA benefits.

Additionally, this plan describes how VA will enhance collaborative efforts with the Department of Defense and increase the use of public and private

ventures through VA's enhanced-use lease authority. By improving the way that we manage the enhanced-use lease process and engaging in productive public and private partnerships, VA can enhance benefits and services to our Nation's veterans and more effectively fulfill our mission.

As we move forward, VA will continue to improve stewardship of the funds entrusted to us by more effectively managing our capital assets and planning to meet the future needs of America's veterans and their families. By employing best business practices and maximizing the functional and financial value of our capital assets through well thought-out acquisitions, allocations, operations, and dispositions, VA will continue to ensure that all capital investments are based on sound business principles and -- most importantly -- meet our veterans' health care, benefits, and burial needs. I am confident that effective implementation of this plan will help us to achieve these important results.

VA's capital investment planning process and methodology ensure a Department-wide approach for the use of capital funds and ensure all major investments are based upon sound economic principles and are fully linked to strategic planning, budget, and performance measures and targets. On May 20, 2004, I transmitted an interim report to VA's 5-Year Capital Plan entitled "CARES Major Construction Projects Fiscal Year (FY) 2004 – 2010" to Congress. This interim report includes VA's highest priority major medical facility construction requirements over the next five years. VA's comprehensive 5-year capital plan will include other specific capital requirements such as leasing, minor construction, and community based outpatient clinics.

The projects listed in the interim report were identified through the CARES planning process as well as the VA's capital investment process, and support decisions identified in my CARES Decision. The CARES process focused on capital requirements at a macro-level by using projections of beds and inpatient and outpatient services. Once performance gaps were identified in the market

plans, business case applications were developed for specific major construction projects in order to fill these gaps. Business case applications were scored and prioritized based on how well they addressed each of the criteria in the capital decision model. Over 100 CARES concept papers and business case applications were submitted and reviewed through VA's capital investment process utilizing criteria I approved in May 2004.

Once Congress approves the FY 2005 appropriations, VA will have more than \$1 billion available to begin renovating and modernizing VA's health care system. In the next six months, VA intends to make 28 design awards, one land purchase, and a construction award for a bed tower at the West Side VA Medical Center in Chicago, Illinois. VA will use available funds from FY 2004 and prior year appropriations and funds appropriated for FY 2005 to carry out these awards. VA will proceed with planning and construction once the requirements of section 221 of Public Law 108-170 are fulfilled, which allows me to carry out major construction projections specified in the final CARES report 45 days after my submission of the interim report that was delivered to Congress on May 20th of this year.

VA/DoD Sharing Opportunities

Sharing between the Department of Veterans Affairs and the Department of Defense is a priority of the President and for both Departments. As my CARES decisions are implemented, we will continue to take all necessary steps to identify and act on available sharing opportunities.

My CARES decision identified 35 promising sharing opportunities. Working through the VA/DoD Joint Executive Council (JEC), co-chaired by VA's Deputy Secretary and DoD's Under Secretary for Personnel and Readiness, VA and DoD have already begun to work more closely toward making a reality of many of these opportunities.

For example, my CARES Decision, as well as VA's 5-Year Capital Plan, includes a number of significant ventures for VA – DoD collaboration including two new federal medical facilities in Denver, Colorado and Las Vegas, Nevada, a joint outpatient clinic in Pensacola, Florida, an outpatient clinic and regional office in Anchorage, Alaska, and an outpatient clinic in Columbus, Ohio.

In addition, the JEC recently established a Capital Asset Planning and Coordination Steering Committee, which will be responsible for identifying and overseeing opportunities that maximize capital asset resource utilization for both Departments. This body will oversee implementation of the VA/DoD recommendations that require capital planning and will seek to maximize productive collaboration between Departments in developing capital asset management sharing opportunities in the future. Both Departments recognize the importance of capital coordination efforts at the local level and the Capital Asset Planning and Coordination Steering Committee is working to improve the stability of VA/DoD partnerships through transition of management at local facilities.

With my discussion of the Department's capital initiatives and VA/DOD Sharing Opportunities as a backdrop, I will now turn to Section 2 of the proposed bill.

Section 2. Capital Leases

Section 2 would authorize me to enter into contracts for leases for the following seventeen facilities:

- (1) Wilmington, North Carolina, Outpatient Clinic, \$1,320,000;
- (2) Greenville, North Carolina, Outpatient Clinic, \$1,220,000;
- (3) Norfolk, Virginia, Outpatient Clinic, \$1,250,000;
- (4) Summerfield, Florida Marion County, Outpatient, Clinic, \$1,230,000;
- (5) Knoxville, Tennessee, Outpatient Clinic, \$850,000;

- (6) Toledo, Ohio, Outpatient, Clinic, \$1,200,000;
- (7) Crown Point, Indiana, Outpatient Clinic, \$850,000;
- (8) Fort Worth, Texas, Tarrant County Outpatient Clinic, \$3,900,000;
- (9) Plano, Texas, Collin County Outpatient Clinic, \$3,300,000;
- (10) Saint Antonio, Texas, Northeast Central Bexar County Outpatient Clinic, \$1,400,000;
- (11) Corpus Christi, Texas, Outpatient Clinic, \$1,200,000;
- (12) Harlingen, Texas, Outpatient Clinic, \$650,000;
- (13) Waco/Marlin, Texas, Outpatient Clinic, \$2,600,000;
- (14) Denver, Colorado, Health Administration Center, \$1,950,000;
- (15) Oakland, California, Outpatient Clinic, \$1,700,000;
- (16) San Diego, California, North County Outpatient Clinic, \$1,300,000; and
- (17) San Diego, California, South County, Outpatient Clinic, \$1,100,000.

Of these 17 leases, the leases in Norfolk, Virginia; Summerfield, Florida; Plano, Texas and San Antonio, Texas are new. The remaining 13 leases are replacement or expansions for existing leases. Please note that the leases in Section 2 should be identified as operating leases because they do not meet the required characteristics of a "capital lease". Capital leases are subject to specific requirements such as being scored under the OMB scorekeeping rules and the requirement that the entire cost of the lease be expended during the first year of the lease.

Section 2 of the bill authorizes for appropriation the sum of \$27,020,000 for fiscal year 2005 for the Medical Care account for the leases listed in this section. My comment on the total amount of the authorization is consistent with my previous comments regarding the authorization of the seventeen leases identified in this section.

Section 2 further authorizes me to enter into a lease for real property located at the Fitzsimons campus of the University of Colorado for a period of up to 75 years. We have been involved in evaluating and planning for a facility for the Fitzsimons site and there is a potential for a joint venture with DOD to provide health care to both veterans and DOD beneficiaries. Of the many issues remaining, the availability of land is a critical one.

The bill provides the Department a new leasing authority. The bill permits the VA to enter into a long-term lease of up to 75 years at the University of Colorado Hospital at the Fitzsimons Campus of the University of Colorado. This authority is necessary for the VA to acquire a sufficient land interest for the construction of a new medical facility on the Fitzsimons Campus. We support this proposal. The VA will enter into a sharing agreement with the University of Colorado Hospital, which will produce economies of scale of benefit to both parties. It is anticipated that this facility will be a joint operation of the Department of Veterans Affairs and the Department of the Air Force.

Section 3. Department of Veterans Affairs Capital Asset Fund

Section 3 of the bill would authorize VA to dispose of its excess real property by transfer to a Federal agency, a state or political subdivision of a state or to any public or private entity and to retain the proceeds generated by the disposals. We support this provision except for the language that limits the authority to the transfer of real property. To prevent any misinterpretation, we recommend that the words “sale, exchange, and” be inserted before the word transfer. This language will allow us to implement the nationwide recommendations of the recent CARES decision in a timely and efficient manner. Further, the section provides that VA receive compensation of not less than the fair market value of the property except in the case of a transfer to a grant and per diem provider (as defined in section 2002 of title 38). Further, the property

would revert to the United States if the property transferred to a grant or per diem provider is used for other purposes. This latter provision could have government-wide implications, so until a thorough vetting of this provision is completed, we are not prepared to opine on it at this time.

The authority may be exercised notwithstanding 40 U.S.C. §§ 521, 522 and 541-545 and the McKinney-Vento Homeless Assistance Act (which provides that unused or underutilized Federal real property may be used to assist the homeless). We support this provision only because VA's homeless assistance programs now constitute the largest integrated network of services in the U.S.. In 2005 VA will spend \$1.5 billion on medical services for the homeless and another \$188 million on programs to return homeless veterans to stable living. These programs include outreach, case management, transitional residential care, rehabilitation care, income support assistance, permanent housing assistance, and follow-up care. We continually ensure that our property policies address the needs of the homeless. Section 3 of the proposed bill further provides that any such transfer shall be in accordance with this section and section 8122 of title 38. Section 8122 of title 38, requires that VA report the proposed transfer in its annual budget document before transferring real property valued in excess of \$50,000 to another Federal agency or to a state or a political subdivision of a state for fair market value. As most parcels of real property exceed the \$50,000 threshold, this would require VA to submit disposal information each time it sought to transfer real property to another Federal agency or to a state or a political subdivision. Therefore, we object to this provision. We suggest the proposal be amended to require the submission of a report along with the budget request for property valued equal to or more than the Major Medical Facility Project threshold identified in subsection 8104(a)(3)(A) of title 38.

The bill further provides that the authority provided by this section may not be used in a case in which section 8164 of title 38 (enhanced use) applies. We

support this provision. The exercise of this authority expires seven years after the date of the enactment of this section. We strongly object to this provision. Should a 7-year limitation be established, we recommend that the Secretary transfer to any account or accounts any unobligated and undistributed dollars remaining in the Fund upon expiration of the authority. The proceeds from the transfer of real property under this section would be deposited in a Capital Asset Fund (the "Fund"), as provided for by this legislation. The bill would also terminate the Nursing Home Revolving Fund and deposit funds therein into the Fund. Further, the bill would authorize to be appropriated to the Fund \$10,000,000.

Amounts in the Fund would have to be used for the costs of actual or planned disposals of real estate, including demolition, environmental cleanup, improvements to facilitate the transfers and administrative expenses. If amounts remain after those expenditures, like expenditures may be made for future transfers. Any remaining amounts are to be used for historic preservation as set forth in legislation. We appreciate the provisions that establish use of the Fund. However, we object to the limitation on the use of the proceeds to historic preservation after expenses. We would strongly support use of the Fund for non-recurring VA Capital projects as well as historic preservation.

Property may only be transferred under this section, or under sections 8117 or 8164 of title 38, after: (a) placing notice of my intent to do so in the local newspapers and in the Federal Register; (b) holding a public hearing; providing notice to the Administrator of General Services; (c) waiting 30 days to determine if another Federal agency has an interest in acquiring the property at fair market value; and (d) thereafter, providing a 60-day notice period for the congressional veterans' affairs committees to review the intended property disposal. We support the report and wait requirement of this section as it relates to 8117, but object to its application to 8164. The basis for the objection is that section 8164 already has specific notification requirements.

Section 3, additionally, would make two conforming amendments to VA's enhanced-use lease statute. First, it would amend section 8164(a) to provide that, before disposing of an enhanced-use leased property pursuant to section 8164, I must determine that a disposal under that section, rather than under the proposed new section 8117 (or under section 8122), would be in the best interests of the Department. Next, it would amend section 8165 (a)(2) to provide that proceeds from a disposal of enhanced-use leased property would be deposited in the proposed new Capital Asset Fund, vice the Nursing Home Revolving Fund.

Further, Section 3 states that the amendments made therein shall take effect at the end of the 30-day period beginning on the date that I certify to Congress that I am in compliance with subsection (b) of section 1710B of title 38. Also, following this certification, I am required to submit an update to Congress on that certification every six months until the certification is included in the Department's annual budget submission. The ability to better manage our capital assets through this section's real property disposal authority and compliance with 1710B(b) of title 38 are not appropriately joined. Conditions that may influence the Department's ability to meet its capacity requirements may not always be within our control. Therefore, VA objects to this provision.

Section 4. Authority to use Project Funds to Construct or Relocate Surface Parking Incidental to a Construction or Non-Recurring Maintenance Project

Section 4 of the bill would add language to Section 8109 that would allow funds in a construction account or capital account that are available for a construction project or nonrecurring maintenance project to also be used for constructing or relocating a surface parking lot incidental to that project. VA supports this provision of the bill.

Section 5. Advance Planning Funding for Major Medical Facilities

This bill would also exempt projects that have already been authorized by law from current statutory notice and wait requirements that apply to certain major medical facility projects. VA supports this provision of the bill.

Section 6. Improvement in Enhanced-Use Lease Authorities

This section would amend section 8166(a) to clarify that, in addition to the bar against subjecting any construction, alteration, repair, remodeling, or improvement of enhanced-use leased property to any State or local law relating to building codes, permits or inspections, such activities are to be exempt from any State or local law relating to land use, unless I provide otherwise. We support this provision.

Section 7. Extension of Authority to Provide Care Under Long-Term Care Pilot Programs

Section 7 of the draft bill would authorize VA to continue furnishing certain long-term care services to a very limited group of veterans still participating in a long-term care pilot program, the authority for which will be expiring soon. VA supports section 7 of the bill.

The Veterans Millennium Health Care and Benefits Act, enacted in 1999, directed that VA carry out a relatively small three-year pilot program to furnish veterans with all-inclusive long-term care services using three different models of care delivery. The effort was intended to test the feasibility, acceptability, outcomes and costs of care using each model. VA patterned the pilot on the Medicare Program of All-Inclusive Care for the Elderly, commonly referred to as the PACE Program. VA conducted the pilot program in three separate locations. In Dayton, Ohio, VA directly furnished pilot participants with all of the services typically included in the PACE Program. In Denver, VA furnished some of the services directly, but paid a capitated amount to a private Colorado PACE provider to furnish the remainder of the services. Finally, in Columbia, South

Carolina, VA served as the care manager, but a private PACE provider furnished all care, receiving a capitated amount from VA. The authority for the pilot program will be expiring later this year, and VA will be reporting to Congress regarding the program in March of 2005, as required by law.

At this point in time, the pilot program is winding down. VA has not been enrolling any new veterans in the pilot for some time. However, a few veterans will still be receiving care under the program when it ends. To ensure continuity of care and avoid disruption in the life of these elderly and frail patients, section 7 would authorize VA to continue to furnish these few veterans with the same services they have been receiving, in the same settings, until December 31, 2005. That time period would allow Congress time to review the post-pilot report, including VA's recommendations, and decide how to proceed. VA also anticipates that by that time, most participants will have moved to a different care setting.

Conclusion

Mr. Chairman, my CARES Decision and accompanying 5-year Capital Plan represent a blueprint for VA's future. Sophisticated forecasting models provide new and more complete information about the demand for VA health care. A comprehensive assessment of VA's facilities has greatly improved our understanding about the condition of VA's facilities. These factors, combined with the experience of conducting the CARES process, leave the Department well positioned to continue to expand the accuracy and scope of its planning efforts. Throughout the CARES implementation process we will keep you and other members of Congress informed and involved and, just as important, we will keep our patients and their families informed and involved.

This concludes my statement. I will now be happy to answer any questions that you or other members of the Subcommittee might have.