# COLLABORATIVE OPPORTUNITY FOR THE RALPH H. JOHNSON VA MEDICAL CENTER AND THE MEDICAL UNIVERSITY OF SOUTH CAROLINA TO SHARE FACILITIES AND RESOURCES

## FIELD HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS

HOUSE OF REPRESENTATIVES

ONE HUNDRED NINTH CONGRESS

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# HEARING ON COLLABORATIVE OPPORTUNITY FOR THE RALPH H. JOHNSON VA MEDICAL CENTER AND THE MEDICAL UNIVERSITY OF SOUTH CAROLINA TO SHARE FACILITIES AND RESOURCES

**MONDAY, SEPTEMBER 26, 2005**

U.S. House of Representatives,
Subcommittee on Health,
Committee on Veterans' Affairs,
*Washington, D.C.*

The Subcommittee met, pursuant to call, at 9:10 a.m., in the Solomon Conference Room 125, Thurmond/Gazes Research Building, Medical University of South Carolina, 114 Doughty Street, Charleston, South Carolina, Hon. Henry Brown [Chairman of the Subcommittee] presiding.

Present: Representatives Brown, Buyer and Michaud.

Mr. Brown. Good morning. The hearing will now come to order.

As Chairman of the Subcommittee on Health, I am very pleased to be joined today by both our distinguished Chairman of the House Veterans' Affairs Committee, Steve Buyer from Indiana's Fourth District; and the Subcommittee Ranking Member, a Democrat, the Honorable Mike Michaud. We welcome both of you to the low country.

Mr. Chairman, I am truly honored to have you with us this morning, and especially appreciate your strong leadership and willingness to work with the Subcommittee on this very important matter. Your persistent efforts have always proven instrumental in bringing VA and the Medical University together in order to advance discussions on collaboration. And for that, I thank you very much.

It is also a real pleasure to have my friend and the Subcommittee's Ranking Member Mike Michaud here in the low country. Mike and I shared a leadership role last year on the Benefits Subcommittee. This year, as I was selected to chair the Health Subcommittee, Mike was designated as the Ranking Member on Health and I am grateful for that. I think we have a very strong working relationship and I was honored to join him recently in his beautiful home state of Maine. Now is South Carolina's chance to return the hospitality we

were shown by Mr. Michaud and his staff. Welcome, Mike, and thank you for joining us today.

I would like to remind everyone here today that our purpose is simple: We are here to conduct an official Congressional hearing examining opportunities for enhanced collaboration between the VA and MUSC. I understand there will be some in the audience who will be hesitant to embrace the idea of collaboration here, but we want to hear from the experts as to whether or not collaboration can be expanded. To that end, I would remind you -- because this is an official hearing -- there will not be an opportunity for members of the audience to speak. There will be plenty of time for that and in fact, I plan to host a number of public meetings here in Charleston, to hear your questions, concerns and hopefully your support once the information is shared in today's official format.

My goal, as the Chair of the Subcommittee on Health, is to improve the health care delivery for our veterans and keep it in step with the 21st Century. Most importantly, I am deeply committed to doing what is right for the veterans of South Carolina. And to that end, I have worked hard to ensure that the veterans in this state are able to access the best and most timely care at a location that is closer to their homes. I have worked to expand the Community Based Outpatient Clinic in Myrtle Beach. Dedicated in March of this year, the new clinic is more than triple its original size, going from 4,200 square feet to 12,800. It includes 16 primary care examination rooms with the capacity to be expanded for 24 rooms as needed. The $2.7 million project also includes on-site digital x-ray equipment and 36 additional parking spaces.

We can look forward to the new outpatient clinic that is being built on the Naval Weapons Station in Goose Creek, which is targeted for opening in 2008. In the meantime, however, on September 13, VA opened a temporary North area VA outpatient facility on the TRIDENT medical center complex.

Here in Charleston, we have a unique and wonderful opportunity to develop a new and innovative model for delivering the highest quality health care to our veterans and set the standard for all other areas to follow.

VA and MUSC have a long-standing and strong history of working collaboratively. Facilitated by their physical proximity to each other, the two medical facilities already share significant amounts of medical staff and research activities. In fact, some 243 physicians who hold faculty appointments at MUSC now treat veteran patients at VA Medical Center. Of those, about 125 to 150 do so on a regular basis, along with another 85 MUSC residents at any given time. This represents over 95 percent of VA's physician staff at the hospital.

Nine years ago, Senator Thurmond took the lead and was instrumental in creating the building where we are holding our hearing

today. The Thurmond/Gazes Biomedical Research Center is shared by the VA and the Medical University and houses the research efforts of both institutions. It is widely claimed as a highly successful model that has served to set a national precedent in the area of collaboration.

In addition to the existing relationship in research, VA and MUSC are already engaged in a significant effort in the area of clinical services. In fact, the VA medical center currently purchases roughly $13 million in specialty medical services. The relationship exists, now we want to see if it can be expanded in order to improve care and at the same time, reduce the need for both organizations to purchase expensive, duplicate equipment and infrastructures. All these factors make this an ideal time to further explore such an option. And that is what we are doing -- exploring.

I want to assure all of you here today, especially all the local Veterans' Service Organizations that are so important to the process, that this is not about VA losing control of the care for veterans or destroying VA's ability to meet veterans' unique needs. It is about advancing an already successful partnership in order to provide the veterans of South Carolina the highest quality of specialized inpatient care in the best and most up-to-date facilities. The bottom line is we are not interested in collaboration for collaboration's sake, we are interested in improving the clinical services provided to veterans through new and innovative delivery models.

I am confident that the panels we have assembled here today will help us better understand how a mutually beneficial collaborative agreement can be crafted and how the many complex and critical issues can be effectively worked out.

I now yield to Mr. Michaud.

MR. MICHAUD. Thank you very much, Mr. Chairman. I want to thank you for your kind hospitality and I really appreciate being in Charleston. It is a beautiful and hospitable city and I want to thank you for the little tour this morning. Last night when I arrived actually Chairman Buyer gave me a little tour driving in from the airport. So it is great to be here.

This is a very important hearing this morning. For several years, the VA has been working the Capital Assessment Realignment for Enhancement Service process. CARES is a very important effort by the VA to realign the VA infrastructure with the current and future needs of our veterans.

As we found in the field hearing in the State of Maine last month, the CARES process to expand access to care for veterans in Maine has been stalled because of lack of funds. The CARES plan and decisions recommended collaboration ventures between the VA and the Department of Defense as well as other entities. Collaborations are appropriate because they have the potential to enhance our service

for our veterans. That is one thing we have got to keep in mind, whatever we do on the Veterans' Affairs Committee, we want to make sure that it benefits the veterans, not only in South Carolina but nationwide.

And I look forward to the hearing today to hear how VA can establish a model process to resolve the complex and important clinical, fiscal, legal and governance issues involved in the joint construction and operation of ventures between the VA and other health care organizations. So I want to thank all the panelists for your testimony today and look forward to hearing it.

I yield back the balance of my time, Mr. Chairman.

MR. BROWN. Thank you, Mr. Michaud. It was really an experience for me to go to Maine, it was my first trip up there, and I know dealing with rural health care for veterans is a big issue that we have got to address, and particularly in areas as big as Maine and with such a few people. I think it is what, 1.1 million people I think living in Maine?

MR. MICHAUD. That is correct.

MR. BROWN. And what is it, 400 miles long or something like that.

MR. MICHAUD. It is almost 28,000 square miles in my Congressional District alone.

[Laughter.]

MR. BROWN. So anyway, we have unique problems as we deal with the health care delivery for veterans, particularly trying to take the health care delivery to the veterans. It was some great sharing experiences up there and I am glad you are here today. Sorry you cannot stay but just a short while.

We really are fortunate to have the Chairman of the Committee, Congressman Steve Buyer. Congressman Buyer is not certainly a stranger to this area, having graduated from the Citadel. He has family connections and we call him the seventh member of our Congressional delegation.

[Laughter.]

MR. BROWN. But anyway, Congressman Buyer, we are certainly glad to have you and we welcome an opening statement from you.

MR. BUYER. Thank you, Mr. Chairman and Mr. Michaud.

First of all, I want to thank both of you for your leadership. More importantly, let me thank you for taking time away to go down to the Gulf area to check out the facilities, the damage to our VA Hospitals in New Orleans and Biloxi, Gulfport. I want to thank you for that.

We are in a very important mission in Congress, trying to find out exactly what were the facts and what went wrong. More importantly, we will have to analyze that VISN and the Secretary is doing that has really not been told enough, how well the VA responded. In the press,

Mr. Chairman, you often hear about the federal response. Well, that is such an over-statement, because I saw the Coast Guard saving thousands of lives. I think they are part of the federal government. I saw the VA do remarkable and heroic and courageous acts, and the first convoy of relief came from Jackson, Mississippi into the Gulfport area. So I look forward to talking with both of you when you return from your trip.

I also am pleased to see that there is such a high level of interest in this initiative in this room here this morning, because improving how we deliver health care to veterans here and across the nation is extremely important, especially at a time when we are at war. I think everyone here would agree that health care is becoming such an important issue in all of our lives, and for South Carolinians and particularly veterans of South Carolina, you have a real champion in Henry Brown. Henry and I shared a special moment earlier this year when both of us had the opportunity give a memorial address at Normandy. As we toured the cemetery and the battlefields of France, even a World War I cemetery, Henry wanted to be in close proximity of his father and where he had served, and I got to see a very sensitive and compassionate side of Henry that motivates him in the service of veterans on this Committee.

I also want to thank the VA's General Counsel, Tim McClain, for his involvement on behalf of Secretary Nicholson, for coming down here earlier. Your personal involvement here is extremely important. I would also like to thank Mr. Mountcastle and Dr. Greenberg and the respective teams of dedicated professionals for their interest in the welfare of veterans at the Charleston VA facility and in this endeavor which you are presently working on. Your willingness to consider the possibilities that some may view as controversial -- change always frightens some people and new ideas can generate emotion. But your willingness to step forward and do this investigation is extremely important.

One of the major concerns I think veterans here in Charleston, in the low country, could have is, are they about to "lose their identity" as a VA Hospital to the University Hospital. These rumors have made their way to Washington. Even unfortunately I think the term "land grab" has been used. I think these types of words have a basis in malice, they are slanderous. These are words that are used by individuals who are ignorant. Ignorant, not that they are not very smart people, they just do not know what it is about yet. So it sort of frightens them, so they use certain words. And this hearing is extremely important because it will be able to dispel some of the myths, it will be able to lay out the processes, the methodology that is being used here. So these types of misplaced words that are being used by some are completely unfortunate.

I have learned in the political arena, Mr. Chairman, that people

will do those kinds of things. But the facts and using cost/benefit analysis and doing what is in the interest of our veterans and how we improve the delivery of health care are extremely important.

And as I look at the federal dollar and I look at Charleston, what the Medical University is doing here, they are doing it because of the use of federal dollars, of HUD grants. So this is a very large federal project that is going on here on the peninsula. So when you think about the federal dollar and how we are bettering health care delivery and services and access here on the peninsula for your citizens here, Mr. Brown -- and there is a history of collaboration and excellent working relationship that Mr. Mountcastle has with Dr. Greenberg -- how do we improve that as we have an ongoing construction project?

I want to thank the CARES Commission, because they have encouraged these two parties to work together. Those negotiations got stalled and now they are back on track and I think this is pretty exciting. All you have to do is look around at this building we are sitting in, and as you mentioned, Mr. Chairman, it's state of the art, cutting edge. These are pretty exciting terms to use, and to think that South Carolina is at the tip of the spear to do that. Only one word I could use to describe that and that would be pride. When I toured this facility this past summer, I could sense that and I could feel that.

So I have complete faith in the veterans who also have the pride in their services at the VA facility. They will see what we are endeavoring to do here and how it will increase their access to care and decrease waiting times and at the same time reduce the federal outlay. That is what is extremely important here because of our responsibility also to the taxpayer. This throw-back of old that I am going to build my own hospitals wherever I want, my own fiefdoms and mausoleums, I think is in a different age.

I want to thank you for calling this hearing, Henry. I look forward to the witnesses and I will have some questions as we proceed.

Thank you, I yield back.

Mr. Brown. Thank you very much, Mr. Chairman, I really do appreciate you coming and being with us this morning.

Our first witness this morning is Mr. Mark Goldstein. He is Director of Physical Infrastructure Issues at the U.S. Government Accountability Office.

The Committee has requested GAO, the agency responsible for review and investigation of federal property, to examine issues surrounding the opportunities for VA and MUSC to enter into a joint venture, and provide the Committee with a report and recommendation.

Mark, glad to have you with us this morning and we look forward to your testimony.

STATEMENT OF MARK L. GOLDSTEIN, DIRECTOR, PHYSICAL INFRASTRUCTURE ISSUES, UNITED STATES GOVERNMENT ACCOUNTABILITY OFFICE

MR. GOLDSTEIN. Thank you very much. Good morning, Chairman Brown, Chairman Buyer and Ranking Member Michaud. I am pleased to be here to provide a preliminary findings on the possibility of VA and MUSC entering into a joint venture for a new medical center in Charleston.

As you know, VA has for many years developed and maintained partnerships or affiliations with university medical schools to obtain medical services for veterans and to provide training and education to medical residents. Today, VA has affiliations with 107 medical schools. These affiliations, one of which is MUSC, help VA fulfill its mission of providing health care to the nation's veterans.

In addition to partnering with university medical schools, VA manages a diverse inventory of real property to provide health care to veterans. However, many of VA's facilities were built more than 50 years ago and are no longer well suited to providing accessible, high-quality, cost-effective health care in the 21st century. To address its aging infrastructure, VA in 1999 initiated the Capital Asset Realignment for Enhanced Services, or CARES, process. In February 2004, the CARES Commission, an independent body charged with assessing VA's capital assets, issued its recommendations regarding the realignment and modernization of VA's capital assets necessary to meet the demand for veterans' health care through 2022. At that time, the Commission recommended replacing VA facilities in Denver and Orlando. But the Commission did not recommend replacing the VA facility in Charleston. However, the Commission did recommend that VA promptly evaluate MUSC's proposal to jointly construct and operate a new medical center with VA in Charleston, noting that such an arrangement could serve as a possible framework for partnering in the future. In responding to the Commission's recommendations, the Secretary stated that VA will continue to consider options for sharing opportunities with MUSC.

My statement today will cover three things: (1) the current condition of the Charleston facility and the actions VA has taken to implement CARES; (2) the extent to which VA and MUSC collaborated on the proposal for a joint medical center; and (3) some of the issues VA should consider when exploring the opportunity to participate in the joint venture.

Our preliminary views are as follows:

(1) The most recent VA facility assessment and the CARES Commission concluded that the Charleston facility is in overall good condition and with some renovations can continue to meet veterans'

health care needs into the future. VA officials attribute the facility's condition to VA's continued capital investments. The CARES Commission recommended renovation of the nursing home care units as well as the inpatient wards in order to meet the need of the projected veterans' population in the Charleston area. To maintain the facility's condition over the next 10 years, officials from the VA facility in Charleston have identified a number of planned capital maintenance improvement projects, including repairing expansion joints, making electrical upgrades and adding a parking deck for patients. VA officials estimate that the cost of these planned maintenance and improvement projects will total about $62 million.

(2) VA and MUSC collaborated and communicated to a limited extent on a proposal for a joint venture medical center over the past three years. In November 2002, the President of MUSC made a proposal to the Secretary of VA to participate in a multiphase construction plan to replace and expand its campus. Under MUSC's proposal, MUSC would acquire the site of the current VA facility in Charleston for part of its expansion project and then enter into a joint venture to construct and operate a new VA facility on MUSC property. Although there has been some discussion and correspondence between VA and MUSC since 2002 on the joint venture proposal, collaboration has been minimal. For example, before this summer, VA and MUSC had not exchanged critical information that would help facilitate negotiations such as cost analyses of the proposal. As a result of the limited collaboration, negotiations over the proposal stalled. However, VA and MUSC recently took some initial steps to move the negotiations forward. Specifically, VA and MUSC established four workgroups to examine critical issues related to the proposal.

(3) The MUSC proposal for a new joint venture VA Hospital presents a unique opportunity for VA to explore new ways of providing health care to Charleston's resident now and in the future. However, it also raises a variety of complex issues for VA. These include the benefits and costs of investing in a joint facility compared with those of other alternatives such as maintaining the existing facility or considering options with other health care providers in the area; legal issues associated with a new facility, such as leasing or transferring property; contracting and employment; and potential concerns of stakeholders. The workgroups established by VA and MUSC are expected to examine some, but not all of these issues. In addition, some issues can be addressed through collaboration between VA and MUSC while others may require VA to seek legislative remedies. It is important to note that GAO has stated over the past few years that federal agencies, including VA, need to re-examine the way they do business in order to meet the challenges of the 21st Century.

To address future health care needs of veterans, the VA's challenge is to explore new ways to fulfill its mission of providing veterans with

quality health care. The prospect of establishing a joint venture medical center with MUSC presents a good opportunity for VA to study the feasibility of one method to achieve this goal. This is just one of several ways VA could provide care. Nevertheless, determining whether a new facility for Charleston is justified in comparison with the needs of other facilities in the VA system, as well as other budgetary claims, is also important. Until all the relevant issues are explored, it will be difficult to make a final decision on whether a joint venture is in the best interest of the federal government and the nation's veterans.

In conclusion, Mr. Chairman, I would like to thank the VA, MUSC and the Committee staff for their assistance in this portion of our review. I would also like to thank GAO's team for its contribution to this effort.

I would be pleased to answer any questions that you or members of the Subcommittee have.

[The statement of Mark Goldstein appears on p. 64]

MR. BROWN. Well, thank you very much for your testimony and we do have a few questions we would like to ask.

Number one, my question would be, what are the key issues that the VA needs to explore in examination of the joint venture proposed to adequately evaluate whether such an opportunity is in the government's best interest? What do you think would be the real selling point to make this project work?

MR. GOLDSTEIN. I think there are a number of issues, Mr. Chairman. And let me first say that I do think that MUSC and VA are certainly now on the road to exploring the issues. The workgroups that have been set up in clinical areas and financial and legal and governance I think are definitely on the road. We saw the interim report on Friday. We have not had a chance to really analyze it, but just even looking at it quite briefly you get a sense that there is some progress going on. The clinical services area specifically seems to have really begun to grapple with the hard issues that they face. So I think we have definitely seen some strong progress very recently in the willingness and the incentive of the two groups to move forward and do this.

Having said that, I think from our view, the challenges that will most -- that need most addressing certainly include the governance structure, especially if there ends up being a joint governing board of some sort. That is an area that may take some assistance from you all in terms of legislation to make certain kinds of changes. It is too early to tell, of course, at this point, but the governance structure is going to be critically important trying to understand who is accountable for what, who is responsible for what, particularly when it comes to providing quality care for veterans, to make sure that VA can still

maintain its mission and be sure to have the accountability that the American public and Congress expects them to have in achieving those goals.

I think the property and the associated transactions still clearly need a lot of work. They are going to have to decide whether or not this is something where property would be purchased by VA, whether it would be leased, whether you could go into an enhanced use lease, whether you could share property of some sort. Legal teams are going to have to look through this. There are obviously some complications and restrictions in many of these areas. Capital leases require certain kinds of budget scoring issues back in Washington. There are a lot of issues there as well that take time. Stakeholder input, I think that would be an area where we have not seen so far the workgroups at this point get input and they may want to do that from employees, from the Veterans' Service Organizations as well. Those voices certainly need to be heard in this. Meaningful measures to determine the joint venture's utility, how will they know what success is. I think that is extremely important as well. Obviously the cost analysis, so they can determine cost versus benefits. The clinical services group has begun that, but there is still a long way to go and obviously you have got to find some way to ensure that the information that feeds into the cost analyses is being appropriate and accurate and valid by all parties, that it is transparent. I think that is very important. And then finally, I think a difficult issue they will have to grapple with is sharing health care information.

In the work that we have done recently I believe for this Committee where we have taken a look at resource sharing between DoD and VA, we found that one of the things that came up repeatedly in the 16 places that GAO visited, one of the biggest challenges was sharing health care information and making networks work.

So those would be the initial observations.

MR. BROWN. I think that is a challenge for us too, as we look for a seamless transfer between DoD and the VA, that is another issue but it is an issue we have got to address.

I noticed in your report, you said that I guess in the next several years, the hospital, although it is in sound condition today, would need some $62 million worth of upgrades or, you know, renovations. If in fact a new facility was constructed, how much of that savings would be incorporated into the new construction?

MR. GOLDSTEIN. The VA has said that they would plan to spend roughly $62 million over the next 10 years to renovate this facility in line with CARES. I could not tell you exactly how much could be say transferred or used if they were to build the new facility, nor do I know at this point because we have not finished our work yet, Mr. Chairman, about how this might compare to two other facilities in the system. When it comes to the standard maintenance that they

are providing for the facility, it is at about two or three percent of operating costs I believe. So it is fairly low, but you could certainly take a look at the $62 million and specific projects and many of those, assuming you were going to build a new facility, could be I suspect foregone. You would have to obviously take a look at the facility and work with the facility's assessment reports of the facility and try and determine what are real priorities that need to be done even as you were to move to a new facility, what had to be done and what could be deferred.

MR. BROWN. Right.

MR. GOLDSTEIN. But that is certainly something that is do-able.

MR. BROWN. Thank you very much.

Mr. Michaud, you have questions?

MR. MICHAUD. Yes, thank you, Mr. Chairman. Once again, I really appreciate you having this hearing down here and for your continued fight for veterans, Mr. Chairman.

I have got a couple of questions. How does the joint venture being explored in Charleston fit into the CARES process and VA's capital planning process?

MR. GOLDSTEIN. Congressman, the VA facility here in Charleston fits in several ways. One, as you know, when the CARES Commission made its recommendations, it recommended that two facilities be completely replaced in the near future, in Denver and in Orlando. But it also put 48 capital projects on the table that were consistent with the CARES program as well. Charleston does not fit directly into those at this point in that they did not recommend a new facility here per se, nor does it make that list of 48 immediate capital projects, I think it is to 2010 I believe.

But in the CARES report, it was indicated, it was requested and the Secretary did agree to take a look at Charleston with respect to determining whether or not there were greater sharing opportunities and whether or not a joint venture could be pursued. And so it does fit in that context, and certainly that is exactly what is occurring. I mean I would add, you know, we have talked a lot over the last couple of years about the need for VA to go through the CARES process and I think it is going to ultimately be very beneficial. The process, like any of these kinds of processes, is not static in that obviously changes occur that require VA to look at other things. So while the process is not set in stone, you use it as a guidepost, if you will, as benchmarks to go forward. Obviously VA is going to have to consider changes, it would seem to me, based on what is occurring in the Gulf. There are going to be some needs there too.

MR. MICHAUD. In your experience, looking at VA efforts to use leasing or other options for collaborative ventures, does VA have a consistent set of criteria and process to explore or evaluate these opportunities in both a comprehensive manner as well as a time sensitive

manner?

MR. GOLDSTEIN. Shortly after MUSC made its proposal to VA, VA did take a look at the project and developed scenarios and some preliminary cost analyses and responded fairly quickly. Then a year later, Congress asked them to do it more formally through a feasibility study, which was more recently updated. So from a time perspective, I think VA has moved fairly well on its own initiative. I think where there has been some concerns is in communicating successfully with MUSC on how they might make this collaboration work.

With respect to any of the specific leasing or owning or sharing arrangements, we have not looked in detail at them. It is a little premature until they kind of come up with a more specific approach and framework for how they will do it. To examine the cost in abstract we decided was probably not something that we would pursue at this point.

MR. MICHAUD. With all the governance, clinical and legal issues which the workgroups are currently exploring, do you think they can all be resolved or will there be some ongoing, continuing problems or concerns that would have to be addressed?

MR. GOLDSTEIN. I think there will certainly be challenges for years to come. I mean I think that the information technology challenge will take years to work out, whatever it is that is decided. It is hard to accomplish even under the best of circumstances for organizations that do not have sort of separate overseers, the federal government on one side with its peculiar needs to serve the veteran population and protect privacy and handle information in certain ways. I think that is a very large challenge that will take a long time. I think the governance structure could take a long time, not in setting it out, but in smoothing it out probably and getting through its wrinkles. It would be a fairly unique approach if indeed they were to create say a joint board that managed it and reported to VA and MUSC, and obviously that is one where Congress would need to be involved. So I think some of these will take a fair amount of time to resolve; yes, sir.

MR. MICHAUD. My last question. In the initial stages of what you have heard so far as far as this joint venture, what will it cost the VA to implement it -- a rough figure.

MR. GOLDSTEIN. Again, I think it would be determined on what approach they end up taking. The VA says that a new replacement facility would be about $185 million, but it is unclear what that facility would include at this point and again, how it would be structured. It might not cost that much. Obviously it could cost a lot more. If you look at the replacement cost for Denver, it is roughly $600 million from what I saw. So that is a lot of money.

MR. MICHAUD. So anywhere from $100,000 to 600 -- I mean $100 million to $600 million?

MR. GOLDSTEIN. That is possible. You know, we have not looked at it, so I am hesitant to even give you a ballpark, but on the other hand, GAO issued a report not long ago when we looked at a facility that VA and DoD had collaborated on and VA decided not to build a new facility and instead to work through building new outpatient clinics, and that cut the cost for them in half, from about $100 million to about $45 million. So I think that is possibly a ballpark; yes, sir.

MR. MICHAUD. Thank you very much. Thank you, Mr. Chairman.

MR. BROWN. Thank you, Mr. Michaud.

Chairman Buyer.

MR. BUYER. To follow up on Mr. Michaud's questions, it is pretty early in the process for you to even give a professional judgment as to what you estimate the cost could be, would that be accurate?

MR. GOLDSTEIN. Yes, sir. That is why I hesitated. That was a rough, you know, building a hospital is going to be in certain parameters, but it does depend on what you put in it and how you structure it.

MR. BUYER. I have read your preliminary findings. Would you restate for me what your present charge or mission is? What are you presently analyzing, so when I get a final report from you, it is going to be based on what?

MR. GOLDSTEIN. We are looking at three things at the request of the Committee. One which is how the -- specifically the condition of the facility here and what its needs would be. Two is whether or not MUSC and VA are working effectively and the kinds of things they are doing to determine whether a joint effort is feasible for them to go forward with. And third is a little different from the testimony where we are talking about, you know, some challenges; to see also whether or not there are some lessons that can be learned, both here in Charleston as well as in Denver for VA in deciding whether these kinds of efforts ought to be developed more widely.

MR. BUYER. For the purpose of open disclosure here, when Denver first started on this initiative collaboration, it caused people to pause and say well, this is rather interesting, what exactly are they doing. And at that moment is when Henry Brown also approached me and said you know, Steve, that is something we could also do in Charleston, we should examine that as a possibility. And do not hold me to this, but it has got to be three and a half, four years ago, we came down here, we met with Dr. Greenberg. At that time, I came down because the Navy had an interest in building something, and at that time MUSC was thinking about doing something, and the VA is always talking about building something. I said wait a minute, this is a lot of federal dollars. So when we look at the peninsula, if you take community health centers, Medicare, Medicaid, VA, TriCare, medical treatment facilities for the military, it is a lot of federal dollars here. And at that time, I had mentioned and suggested, you know, if you want to build a billion dollar campus, do it more up on the north side.

The other would be to MUSC that, why do you not get in tough with the same firm that is doing the consulting with regard to Denver? And that is what they did. So that has been an initiative on the inside that has been working.

I also then, observed what was occurring in Denver -- there was a complete breakdown in leadership personalities there between the VISN director and the hospital director of the university. When you go out there, I want you to take a look at that a little bit more for the Committee, about where they went in the process and what went wrong, and the lessons learned that can be helpful to us here.

MR. GOLDSTEIN. In fact, we are going out there next week, so we appreciate the insight.

MR. BUYER. Oh, that is wonderful, because there are those who are against collaboration no matter what, even though they do not know anything about it -- I am against it -- you are always going to have that -- I am against it. And some feel that well, if all I have to do is go into the veterans' community and spin up the veterans and tell them how bad it is going to be for them, therefore, it will fail here because that is what they did in Denver. I believe that is false, based on all the personal knowledge that I have. So I am interested for you to ask those questions when you are out there, because I know how it went down, but I want to hear it from your investigation, okay?

MR. GOLDSTEIN. Sure, we will be happy to.

MR. BUYER. The other is with regard to CARES. CARES was a snapshot in time, was it not?

MR. GOLDSTEIN. That is correct, it anticipated being updated over time.

MR. BUYER. Correct. So as I noted in your report, OMB and GAO have identified benefits cost analysis as a useful tool for integrating social, environmental, economic and other effects of investment alternatives when making a decision. Is that correct?

MR. GOLDSTEIN. Yes.

MR. BUYER. The quote "other effects" right now on the conscience of the nation is weather -- hurricanes. So we know now its powerful effect in the Gulf and as a result two members of this Committee are going to go down and have a look at it. We saw what happened to the VA facility in Gulfport. We know we have got serious problems with that VA hospital in New Orleans, whether or not we can return to that facility.

I am anxious to get into this with the next panel, but I want to keep it on your conscience that Charleston is at sea level, right?

MR. GOLDSTEIN. Yes, sir.

MR. BUYER. So if we are going to be building a VA facility, right now, as you do your report, I would like to know about this present VA facility and maybe we can get into it with the next panel what it is built to withstand. And as we move forward in any form of col-

laboration, if in fact a decision is made to build the facility and we have shared arrangements with Charleston, what do we need to do to harden it against what, Category 4, Category 5? As we examine those construction projects, Mr. Michaud, Mr. Brown, you know, you are going to have to look at those effects of the hurricane, because the country is not going to be too happy if we are going to make these multi-hundred million dollar investments and we have not taken that into account.

The other thing I want to reiterate is that yes, CARES did not include Charleston in the 48 projects across the nation, but it did cite the potential of joint venture between VA and MUSC as a possible framework for future partnership, is that correct?

MR. GOLDSTEIN. Yes, sir, that's correct. And the Secretary did agree to look at sharing opportunities.

MR. BUYER. You said that this could be a model that could be leveraged. Could you expand on that a little bit?

MR. GOLDSTEIN. Sure. I think obviously what we need to pursue understanding whether it could be a model is better information, which the workgroups and however else they decide to pursue this will get for the Committee and for VA and MUSC to determine. But I think what is required is some specific criteria that would help all the organizations, all the stakeholders whether or not this can be a model. It certainly is not GAO's place to determine what those criteria would be, but there needs to be a framework that would include whether or not this can be successful and what success would mean for joint ventures of this nature, so VA could determine here are opportunities that we can pursue and the climate is right and the kinds of measures and situations are right. We have seen this before, this fits into our model, therefore, we could pursue it with little risk.

MR. BUYER. There is a reason that we have asked the GAO to come in. It is because even though CARES gives us encouragement for the VA to move toward a joint venture, explore the possibilities, it got stalled. There was not the best of communications between the VA and MUSC, and MUSC to VA. How do we encourage that, how do we keep it going?

You are our independent set of eyes on this process as we develop a model and then as the model is developed, in doing the cost benefit analysis -- because it has to be mutual, it has to be in the mutual interest of the Medical University, and it has to be in the mutual interest of VA.

And the next panel will explore that, but there is a fear on our standpoint. Our fear is that we want to build a model that is successful and that is the reason we have GAO in, because not only are we going to attempt to build this model, but what are the right benchmarks, measurements of success, how do we make these determinations in the decision-making process?

So, Mr. Chairman, I want to thank you for getting GAO involved in this process. I think it is extremely important and we are going to have an ongoing dialogue as we oversee this process. And I think your willingness and your leadership on this -- I think is pretty exciting to challenge anew, because innovation can always be frightening to the defenders of status quo.

MR. GOLDSTEIN. Thank you, I appreciate your comments, sir.

MR. BUYER. I yield back.

MR. BROWN. Thank you, Mr. Goldstein, for coming and giving us this great information and we look forward to continuing dialogue as this process moves along.

MR. GOLDSTEIN. Thank you, Mr. Chairman.

MR. BROWN. Thank you.

Before welcoming the second panel -- and we are glad to have you all here this morning, but Mayor Riley, the great Mayor of this City, was going to come and have opening remarks but he has had a death in his wife's family and so he was late coming. He is on the scene and we would like to give him just a moment to welcome everybody to the City of Charleston.

Where is Mark? Mark, I was going to recommend that you stick around for a couple of days and sort of get a good view of the lay of the land here. It is hard to see Charleston in a day.

He should be here shortly. But before he comes, I will go ahead and introduce the panel and at least we will have that little part taken care of.

Our second panel is officials from the Department of Veterans' Affairs and the Medical University of South Carolina. Representing VA is the Honorable Tim McClain, VA General Counsel. He serves as the chief legal advisor to the Secretary and the Department. In January 2005, Secretary Nicholson designated Mr. McClain as the interim Chief Management Officer. As CMO, Tim is also responsible for, among other things, the Department's finance policy and operation of the real property asset management. With him is Mr. Mountcastle from the VA Hospital here and we are really glad to have you on the panel. The other members are Mr. Raymond S. Greenberg who became the eighth President of the Medical University of South Carolina in 2000. He has authored about 150 scientific publications and Dr. Greenberg is nationally recognized for his research on cancer and he has served on many national scientific advisory boards. And with him is Mr. Moreland from the VA Pittsburgh Health Care System.

Gentlemen, I welcome you here, but before I give you a chance to give testimony, we have our great Mayor from the City of Charleston. Mayor Riley, if you would just say a few words, we are grateful to have you.

STATEMENT OF JOSEPH P. RILEY, JR., MAYOR, CITY OF CHARLESTON, SOUTH CAROLINA

MAYOR RILEY. Thank you very much, Mr. Chairman, members of Congress, members of the Committee, members of the staff, ladies and gentlemen. I apologize very much for being late today.

My dear mother-in-law passed away this weekend. She was like my mother and an extraordinary woman, one of the most extraordinary people I have ever met. So I have been in the other part of the state, the funeral is tomorrow. But I left in dark, many miles away, to come down here today because of the importance of this meeting and in part because of her feelings about this, which I will explain to you right away.

My father-in-law was a veteran, her husband. She was widowed in 1978. He fought for our country in World War II, he was in the Army during the Korean Conflict. And in the later part of his life, he needed and received wonderful care from the Veterans' Hospital system in our country.

So a few months ago, when there was an article in our newspaper about the possibility of the Veterans' Hospital -- a new Veterans' Hospital -- being constructed as a part of the Medical University of South Carolina Hospital, she called me. She was living here then and she said what a great idea, isn't this wonderful, what a marvelous thing for the veterans. She was calling as the spouse of a veteran seeing the possibility here of our veterans, those who risk their lives and give their health and have their future longevity diminished in the service of our country, that they have the very best, the best that is possible.

And to me, Mr. Chairman and members of the Committee, that is what this is about. Beyond -- which I will speak about briefly -- the importance to Charleston and the Medical University of South Carolina, it is an opportunity -- and the care at the Ralph Johnson Medical Center is extraordinary. I like going in that place, the feel, the throb, the spirit of all the people from the volunteers pushing the carts to the senior staff is absolutely extraordinary. But for the veterans to have the opportunity in this new world class medical hospital complex, to have their own independent, named, separate yet connected, veterans' hospital with link to the best that is available in the world. If that veteran, if one of my father-in-law's colleagues or someone like him needed the best heart care, the best cancer care, the best whatever care, it is right down the hall in this wonderful system.

When we started working with the Medical University and they looked at the possibility of building their new 100-year plan someplace else other than right here. We worked with them because we saw, from the City's standpoint, the opportunity to create a world class medical campus right connected in the historic part of our City.

And we together laid out the plan of the system of hospital buildings wonderfully gracing the streets and with a wonderful form, yet connected so that you would have this series of hospital buildings along Courtenay Street connected with this extraordinary medical university campus. And it was then seeing the potential of making the VA a part of this.

So we really dropped everything we were doing almost from a planning standpoint, got together with Dr. Greenberg and his wonderful staff, with our neighborhood, with the people and redid our zoning ordinances, did our plans, did our height ordinance -- Congressman, you went to the Citadel, as I did -- to respect the wonderful quality of the built environment in Charleston, but to make it fit too, so we came up with this fabulous plan for this wonderful new medical campus with the VA with its independence, with its visibility, with its separateness, yet connected to what we know is going to be one of the great medical centers in our country.

So on behalf of my dear mother-in-law and lots of people like her whose loved ones depended upon the care of the Veterans' Administration, we wholeheartedly endorse this opportunity which we believe can become a new national model for the future for how the VA can give even greater, more splendid care to those who risk their lives for our country.

Thank you very much.

MR. BROWN. Mr. Mayor, thank you very much for coming and certainly extend my sympathies to Charlotte and the family.

MAYOR RILEY. Thank you, sir.

MR. BROWN. We are grateful for your service and your leadership in this City. Is it 28 years now?

MAYOR RILEY. I am in my 30th.

[Laughter.]

MAYOR RILEY. Time flies when you are having fun. I was very young when I was elected.

MR. BROWN. You are still very young and I know that you and I both will have a long career. Anyway, we are grateful for your involvement in this and we are certainly grateful that you would take your time to be with us this morning and we certainly look forward to continuing dialogue with this panel.

Thank you.

MAYOR RILEY. Thank you, Mr. Chairman.

MR. BROWN. Mr. McClain, we will recognize you and you may begin.

STATEMENT OF THE HONORABLE TIM S. MCCLAIN, GENERAL COUNSEL, DEPARTMENT OF VETERANS' AFFAIRS accompanied by MICHAEL E. MORELAND, DIRECTOR AND CHIEF EXECUTIVE OFFICER, VA PITTSBURGH HEALTH CARE SYSTEM and WILLIAM A. MOUNTCASTLE, DIRECTOR, RALPH H. JOHNSON VA MEDICAL CENTER; RAYMOND S. GREENBERG, M.D., PRESIDENT, MEDICAL UNIVERSITY OF SOUTH CAROLINA accompanied by JOSEPH G. REVES, M.D., VICE PRESIDENT FOR MEDICAL AFFAIRS AND DEAN, COLLEGE OF MEDICINE and W. STUART SMITH, VICE PRESIDENT FOR CLINICAL OPERATIONS AND EXECUTIVE DIRECTOR, MEDICAL UNIVERSITY HOSPITAL AUTHORITY

STATEMENT OF THE HONORABLE TIM S. MCCLAIN

MR. MCCLAIN. Thank you very much. And first of all, thank you for calling this hearing. Ranking Member Michaud, thank you and Chairman Brown for your leadership in this aspect. This Subcommittee is very, very important. Health care obviously is one of our main businesses; in VA with over 170 facilities, we are the largest integrated health care network in the United States. Chairman Buyer, thank you so much for those kind comments about the VA and the response to Katrina and Rita. I know that you went down and toured the VA facilities after Katrina in New Orleans and Gulfport and have seen the devastation there, especially in Gulfport, which essentially looked like the insides of the building had gone through a blender. It completely gutted buildings including drywall. There was a chapel that I believe you went into that had no pews. There were pews before the storm and it was completely denuded of pews; and other things like sinks and things were deposited in the chapel -- tremendous devastation.

We appreciate the support especially for our fourth mission and the fourth mission is emergency response, and also the kind words. VA is continuing today to respond to Katrina and to Rita and we have, as many government agencies do, a 24 hour command center, if you will, to respond to these types of issues. Probably before 9/11, we could not have responded as we did, but through the leadership of the Secretary and General Kicklighter who set up our response team, it has been exemplary I think and it all is owed to the employees of VA. So thank you, sir, for those comments.

And also I think we have something which is a real step forward as a start. We are sitting here today with President Greenberg and we are here to testify together as to what we are doing here in Charleston and how we intend to move forward. And thank you for the opportunity, and as we sat here in this particular room I think on August

1 for our meeting, it was your impetus, Chairman Brown and Chairman Buyer, that we actually had to get down to the hard work and the hard work being that we actually sit there and open the books and show each other where we are going and what we are doing and how we intend to get there. Thank you very much for that opportunity.

Through the leadership on the VA side; Bill Mountcastle, he is the Director here at the Ralph Johnson VA Medical Center, the Undersecretary for Health, Dr. Perlin, asked Mr. Michael Moreland to come in. He is the Director of the VA Pittsburgh Health Care Center and has direct experience in these sort of collaborative efforts in pairing with an affiliate in order to get a bed tower built in Pittsburgh, and so Dr. Perlin asked Mr. Moreland to come in. And I think it has been a very, very good relationship so far.

Following our meeting on August 1, dozens of dedicated health care professionals -- financial, legal experts, construction experts -- from VA and MUSC began meeting to explore the most advantageous future relationship of the two public entity health care delivery networks.

Like many Veterans' Affairs Medical Centers, the Charleston VAMC has a very close relationship with its affiliate. Successful collaboration between VA and the Medical University has been very successful for many years. This collaborative relationship recently included the signing of an enhanced use lease which allowed MUSC to begin construction of their phase one facility. As the planning for MUSC's other major construction projects unfold, there may be additional opportunities to partner in the care of South Carolina's veterans and also could include active duty service members and dependents from the Department of Defense.

The Collaborative Opportunities Steering Group has begun its work and is developing opportunities for a new model for future collaboration in the short term and the long term. The group is reviewing opportunities for enhanced collaboration that could occur in the short term perhaps for inclusion in MUSC's current construction, and in the longer term. All options must be fairly evaluated before taxpayer dollars are committed to any major construction project. Should the Steering Group develop proposals to embark on a joint construction project at Charleston, it will have to be in concert with VA's CARES decisions and the Department's long range construction goals, as normally are published in our five-year capital plan. We also have to be mindful of the potentially heavy financial impact of Hurricanes Katrina and Rita and in that vein, we have to also take into account the possible increased construction costs that this may countenance along with an increase in materials, such as steel and concrete and labor and such. So there may be increased costs, not only in Charleston, but across the United States.

The Steering Group has produced an interim report and it has been

presented to the Committee and is available here today. And I would like to ask that that report be made a part of the record, along with my full written statement.

MR. BUYER. [Presiding] It will be made part of the record, with no objection.

MR. MCCLAIN. Thank you, sir.

[The material referred to appears on p. 114]

MR. MCCLAIN. While VA is very optimistic about the potential for a federal-state model, we are also realistic enough to know that we will keep an open mind and explore all options for our veterans before committing any scarce taxpayer dollars. We hope that the Department of Defense will consider joining our planning efforts. The President's Management Agenda has placed a very strong emphasis on VA-DoD sharing and our staff has been directed by the Secretary to identify every opportunity for joint health care operations with the various components of DoD.

Whatever options the group puts forward, we are confident that by continuing to work together to assure a mutually beneficial plan, VA can enhance care to veterans while building on its collaborative relationship with MUSC.

Mr. Chairman, that concludes my statements and the panel will be glad to answer any questions.

MR. BUYER. Thank you very much, Mr. McClain.

Dr. Raymond, you are now recognized.

[The statement of Tim McClain appears on p. 91]

MR. BUYER. Dr. Greenberg, let us just wait a second, without recessing the Committee.

[Brief pause.]

MR. BROWN. [Presiding] I apologize for having to leave during your presentation, but I had a chance to read it last night and we thank you for your presentation and we will hear from Dr. Greenberg and then we will open it for questions I guess when both panel members are concluded.

Dr. Greenberg, thank you very much for being here today.

STATEMENT OF RAYMOND S. GREENBERG, M.D.

DR. GREENBERG. Thank you, Mr. Chairman, Chairman Buyer, Ranking Member Michaud, it is an honor to be invited to present testimony this morning and it is a special privilege to share our thoughts again and host you on the campus of the Medical University of South Carolina.

First and foremost, we are here to tell you how much the Medi-

cal University values its relationship with veterans and with the Veterans' Administration. South Carolinians, as we have already heard this morning, have served our nation in the armed services with pride and with distinction. Many have suffered serious health consequences from their service and it is a privilege for us to be able to help care for these veterans as a partner with the Veterans' Administration.

Our relationship with the VA is deep and it is long-standing. We work as colleagues with the VA in every aspect of our mission. In clinical care, virtually all of the attending physicians at the Ralph Johnson Veterans' Administration Medical Center are MUSC faculty members. In the education arena, all of the physicians-in-training at the Charleston VA Medical Center are in MUSC residencies. With respect to research, many of the most productive scientists at MUSC are investigators in the VA system. In fact, the facility in which we are meeting this morning, as has already been mentioned, is a very tangible symbol of our collaboration. The Strom Thurmond Research Building is owned by the Medical University, but half of the laboratory space is leased to the VA to conduct its scientific work. This joint research building, now in operation for more than eight years, is one of only a handful of such facilities in the country. It works and it works well. We believe that the exact same type of success can be achieved by coordinating facilities in the clinical arena.

Now before proceeding further, let me emphasize here that the first priority in considering any linkage between the Medical University and the VA Hospital is to better meet the health care needs of veterans. It is our position that any arrangement that does not improve health care for veterans is not a good arrangement for anybody. Let me repeat that -- it is our position, the Medical University's position, that any arrangement that does not improve the health care of veterans is not a good arrangement for anyone involved.

In that light, let us advance the case for closer coordination of hospital facilities. First, both the Ralph Johnson VA Medical Center and the Medical University have aging hospitals. Both have been maintained admirably, but the fact remains that they were designed 40 to 50 years ago and as a result, cannot accommodate the size and complexity of current state-of-the-art medical equipment. Therefore, they are not the best environment for delivering state-of-the-art care. Recognizing those limitations, the Medical University has begun the stepwise process of replacing its hospital, the first phase of which is under construction across the street, as you can see from the steel going up, and as Chairman Buyer mentioned, financed by the Department of Housing and Urban Development. The immediate adjacency of this site to the Ralph Johnson VA Medical Center makes it feasible to build facilities in a cooperative way.

We have already heard about the devastation of Hurricane Katrina

on the Gulf Coast and it is a warning of what could happen in Charleston. The Ralph Johnson VA Medical Center is built on low-lying land adjacent to a tidal river in a hurricane prone coastal area. It also sits in a city with a history of destructive earthquakes. This facility was designed prior to current standards for wind, flood and earthquake resistance. Let us not allow the disaster of Hurricane Katrina to be revisited in this particularly vulnerable setting.

Third, building coordinated facilities would allow sharing of infrastructure, such as expensive operating rooms and imaging equipment. By avoiding duplicating this infrastructure, money could be saved on both sides and be redirected back into providing more services to veterans. Everybody in this room is well aware of the spiraling costs of health care and anything -- anything -- that can be done to reduce costs is something that warrants our support and encouragement.

Fourth, we believe the quality of care will be improved by colocating facilities. For example, in certain specialty areas where the Medical University is nationally recognized, such as the treatment of digestive disorders, the Ralph Johnson VA could be designated as a VA Center of Excellence so that veterans would not have to travel from their homes in South Carolina to more remote specialty centers such as Atlanta. From the VISN level, a center of excellence in Charleston would allow consolidation of some services here, avoiding duplication elsewhere.

Let me state emphatically that this is not a proposal for the Medical University to "take over", in quotes, the operation of the VA. We do not want to take over running the Veterans' Administration Hospital, we do not think that is appropriate. Quite to the contrary, we want to preserve all of the current advantages of a dedicated VA hospital, while saving the federal government money and increasing service capabilities. Any coordination of facilities should be guided by principles to protect the interests of veterans and those who serve them.

First, there would be a dedicated veterans' tower so that veterans would not be housed interspersed in with other patients.

Second, the VA Medical Center identity would be displayed prominently on its facility.

Third, veterans will be guaranteed to have equal or preferred access to any and all shared facilities, as they do now.

Fourth, the dedicated employees of the VA Medical Center would be given every consideration in any integration of staffing.

There is no existing model for what we are proposing, so we cannot just simply go out and copy what has been done elsewhere. The hard work of exploring this opportunity has begun, as has already been alluded to, by the VA and the Medical University. We have had meetings on a weekly basis, they have been highly productive and there has been, I believe, a tremendous spirit of cooperation demon-

strated on both sides. As we have already heard alluded to, there have been four working groups organized around clinical integration, governance, finance and legal matters. An oversight group has been established to set the general direction. The interim report that has already been alluded to and now entered into the record of this meeting demonstrates the progress that has taken place.

Again, Mr. Chairman, I thank you for the opportunity to be with you this morning.

[The statement of Raymond Greenberg appears on p. 95]

MR. BROWN. Thank you very much, Dr. Greenberg and we are grateful for this dialogue and feel like it is a good opportunity to explore all the issues to be absolutely sure that the veterans are the benefactor of more timely health care and better quality of health care too.

I would like to ask a question to both of you, if I could, and Mr. McClain, if you would answer first and then we will get Dr. Greenberg's reaction. How would the proposed joint venture improve access to health care to veterans in the future and which services and how?

MR. MCCLAIN. Rather broad question, Mr. Chairman.

MR. BROWN. I will leave it to your discretion.

MR. MCCLAIN. I am not sure I can fully answer that question at this time. As you are aware, we are at a place where we are still learning about MUSC and I think they are learning about us and no decision has been made one way or the other as to how this should look. But certainly we have to address -- whatever comes out of the steering group has to address three things as far as VA is concerned -- quality of health care, access to health care and improved cost.

And so that is how we are looking at, and I know that is how Dr. Greenberg is looking at it also, but we are simply not far enough along, as I understand it -- now Mr. Moreland, Dr. Greenberg and Mr. Mountcastle have been involved in these weekly meetings and I have not, and Dr. Greenberg may be able to address that a little bit more succinctly than I can.

MR. BROWN. Okay, Dr. Greenberg, you want to give it a shot and then I will have another question.

DR. GREENBERG. Well, very briefly, Mr. Chairman, I think that I agree with Mr. McClain that we are still early enough in the discussions that we cannot get a definitive answer, but I think we could give some suggestions where in principle access could be improved.

One issue that has been adequately demonstrated over the last few weeks is that in emergency situations, we do not have within the VA system and within the larger health care system, surge capacity for dealing with emergency situations, whether manmade or natural disasters. We were asked to provide hospital beds for evacuees from the Gulf area. It was very difficult to find that capacity within our hospitals, as I am sure it was within the VA system. We have done

everything we can to make health care efficient and that leads to taking extra beds out of capacity.

I do believe this proposal would allow building some surge capacity into the Veterans' Administration system and to use those beds effectively by leasing them on an interim basis to the Medical University to occupy.

I also think another area where access could be improved is very specialized services and very specialized medical equipment where it does not make sense for the VA to purchase equipment on its own because they do not have enough volume to justify it. If they were part of a collaboration, they would have access to PET scanners, radiation therapy facilities, advanced robotics in operating rooms and so forth.

So I do believe there are opportunities but I certainly agree with Mr. McClain that we are still at a very early level of exploring those potentials.

MR. BROWN. Mr. McClain, what are the primary legal issues and what obstacles do they pose to pursuing a joint venture? I know this is new ground, what do you see the obstacles from the legal side?

MR. MCCLAIN. It is certainly potentially new ground because we are looking for a new model in this case. And potentially we are looking at -- and there is a legal appendix to the report itself and it really begins to address -- it is the progress report of the legal workgroup beginning on page 11 -- and it begins to address those particular issues and I would have to start first with real estate, as to if we were to move, where would that be, how do we acquire the property, what interest do we acquire in the property, the type of financing that we are talking about. Also if there is any sort of sharing of facilities, what does the agreement look like and if there is any sharing of staff, what the agreement looks like. So there are a tremendous number of legal issues that could come into play -- employment law, real estate law, appropriations law. And we have a very, very experienced legal working group that is prepared to address each of those questions as they are raised by the steering group.

MR. BROWN. And if I might ask both of you that same question, how are the committees coming along and when do you project you might have some interim report.

MR. MCCLAIN. Dr. Greenberg.

DR. GREENBERG. Let me start. It has already been alluded to in the GAO report that there is not a history of great communication between the entities and I think that has to do somewhat with the complicated organizational structures that are involved here. But since you and Chairman Buyer came down here and really charged us to work together in a collaborative way and organize the four working groups, and since the Undersecretary designated Mr. Moreland to help coordinate that effort, I have to tell you it has been a totally different dialogue between the parties. We have been talking in these

workgroups on a weekly basis. It has been a very constructive dialogue. We have learned about some interesting things that have been done elsewhere, such as in the Pittsburgh situation and in New York State and I have to tell you, I am very grateful for your influence in helping get the dialogue really started.

MR. BROWN. Thank you both of you very much.

Mr. Michaud, do you have questions?

MR. MICHAUD. Yes, I do, Mr. Chairman.

Dr. Greenberg, if the VA is unable to make a final decision on the joint venture in time for the university to move forward with phase two, will the university still be able to secure the funding that it needs for the project?

DR. GREENBERG. Mr. Michaud, we of course are working very hard on our separate plan and we have a financial feasibility study which indicates that we should be able to move forward independently. Obviously our desire is to not foreclose any opportunities to collaborate. As Chairman Buyer alluded to, early on people seemed to think that we were particularly interested in the land.

Our Board of Trustees in choosing to build on this site -- and Mayor Riley alluded to the fact that we were evaluating other locations -- determined that the 16 acres that the Medical University currently owns is adequate to build all phases of the Medical University facilities. So we believe that we could certainly build a stand-alone facility. We just think it makes much more sense to work in partnership with the VA.

MR. MICHAUD. And as I stated in my opening statement, I think it is important to be able to collaborate everywhere in any way that you can to have, you know, that synergy. I guess this question is also for Dr. Greenberg and Director Moreland.

As co-chairs of the steering group, how do you plan to involve the local Veterans' Service Organizations, and employees in the working group in this process.

MR. MORELAND. At this point, again, it is very early in the process and so we have really been meeting together to have something to communicate. What we have decided is that our communication right now is to let people know that we are working together, we are working in a cooperative spirit, we are working to explore options. And that is really all we can communicate right now. I think in the future, we will need to sit down and talk about how to pull other people in to gain input from others. We have not gotten to that point yet, but that would be something we would certainly look at in the future.

MR. MICHAUD. But is it better in the initial stage to have everyone that is going to be involved in this upfront? I am not talking about a huge group, but planning the process and looking at some of the testimony, there are a lot of questions out there from the VSOs and I

am sure the employees as well. So why not involve them in the initial process to help ease it? Because part of the problem I think as Chairman Buyer mentioned, there is a lot of concern out there, and is it not best to deal with it upfront?

MR. MORELAND. I think we will take your comments back for feedback and we can sit down and discuss that and look if there are ways that we can advance our time line on getting other input.

MR. MICHAUD. Mr. Greenberg, we heard earlier from the GAO when you look at the maintenance costs and the $62 million I think, what is the maintenance costs on your existing facility, what portion of your budget, is it two or three percent similar to the VA?

DR. GREENBERG. I think it is probably in that range. We have about a $650 million a year operating budget in our hospital, which is compared to the VA at about $150 million, so we proportionately spend more in absolute dollars, but percentage-wise it is probably in a very similar range.

MR. MICHAUD. Playing the devil's advocate, and as I stated, I think it is really great to collaborate. It is very important, but also with the addition of Hurricane Katrina -- and I want to thank the VA for your quick response in that effort -- but playing the devil's advocate, looking at the GAO report, it talks about the facility being in good condition, while some renovations definitely will help out. There are a lot of questions from the veterans' groups that have not been answered and I am sure with the working group, they probably will be addressed. When you look at the CARES process, they have already made their recommendation, we had a hearing earlier in the State of Maine, and CARES recommended I think five additional clinics in Maine that would actually cost about $5 million.

Now, as a member of Congress when we look at the GAO report saying that this is in good condition, how can we go back, not only in Maine, but other areas where CARES has recommended some additional facilities, to go back to them and say well, we are going to spend millions and millions of dollars here and yet we have not taken care of something that is actually ready to go under the CARES process? I guess I will ask Mr. McClain first and then if you could respond as well.

MR. MCCLAIN. Mr. Michaud, thank you for the question. Obviously any model that results from this collaboration needs to go back to VA and all of the other criteria need to be applied to it, from, as I mentioned, our five-year capital plan, our CARES funding, those sorts of things are all going to be applied to it and looked at through our capital investment process. And the idea, as I understand this, is to work with one of our very, very close affiliates to see if we can come up with a national model that can be rolled out across the United States that is a model that will ensure quality, ensure access and save money. And the jury is still out on that. We do not know the

answer to that yet.

If it is simply a type of model that is a one-off, in other words, it works in Charleston but not anywhere else, I am not sure where that fits into our national planning. And so we would really like the model to be able to -- if there is one -- to roll out nationally and save us money in multiple locations, not just Charleston.

DR. GREENBERG. Mr. Michaud, if I could just add briefly that as someone who runs a hospital, I think you have to look at what is the capital outlay and then what are the operating costs over time. Running an older hospital is an inefficient vehicle in the long term. And I do believe that there can be cost savings over the next 20 years in a newer facility with new equipment and shared utilization of it.

So you are absolutely right, if you only look at capital investment up front, it may look like it is not a good financial deal, but if you look at it in the context of what are you going to be investing over the next 20 years in the operating expenses, I think you might come to a different conclusion.

At the same time, let me say that we are just beginning that kind of financial analysis now, so we cannot bring you definitive numbers, but I think that where you will find the cost-savings is over the longer term.

MR. MICHAUD. If I might, Mr. Chairman, a follow up question actually to Mr. McClain. Does that mean that the proposals under the CARES process, that actually looks currently at a much smaller level where hospitals are willing to, you know, work for these clinics, are going to be put on hold?

MR. MCCLAIN. No, sir, I would not say that.

MR. MICHAUD. Glad to hear that.

[Laughter.]

MR. MICHAUD. Thank you very much, Mr. Chairman.

MR. BROWN. Mr. Chairman.

MR. BUYER. Mr. Moreland, I want to thank you for accepting the challenge, and I would like to hear from you your comments on the testimony that you have heard so far.

MR. MORELAND. It has been a pleasure to come down here and meet the wonderful people in Charleston, South Carolina. I have spent some time in the south, living there and now I live in Pittsburgh, which is not exactly the south, and I have enjoyed coming down and meeting the people here. Dr. Greenberg and his staff have been great to work with and I think we are making really nice progress in understanding each other, making sure that we can start to move toward understanding each other's financial situations, because they are just a tad different, and making sure that we can make some move in that direction.

We both understand -- and I think Dr. Greenberg said it very clear-

ly -- we both understand that at the end of the day, we may not find something that works, but if we do, it will be something that will be better for veterans, improve access, improve costs. So we are really putting very sharp pencils to paper to work together to try to find something that could be a good model for us.

So I think we are making good progress. The workgroups are very energetic. We have conference calls every week and we have been down here just a couple of times. We have been talking earlier to the side, we will have a conference call again this coming Wednesday morning. So I think we are making good progress, sir.

MR. BUYER. I have heard two words here this morning used that I will link with a preposition. The two words have been "synergies" and "excellence". It is synergies for excellence, that is where I think we are going, so I am putting it together with a preposition.

So when you think about synergies for excellence, I think that is what our pursuit really is and from my standpoint, gentlemen, I want to make sure that we have some form of a veterans' preference, a pavilion, a place where they can go and they have their comraderie, their own identity. I know some veterans are saying, you know, I want to make sure that I am with my comrades and that they are given preference. And that is what Dr. Greenberg has talked about. So those are meeting some of our objectives.

But in order to create the synergies of excellence to take our health care to the cutting edge, it is not only that it benefits us, in order for synergies of excellence to work, it benefits the population as a whole. And for the fact that we cooperate here with a research facility and press those barons of science to benefit all of our society, this is pretty exciting as an endeavor. So I want to thank both of you.

I noticed that you have a memorandum here from Dr. Perlin signed by Michael Cussman that went to you, Mr. Moreland, this is the charge memorandum.

MR. MORELAND. Uh-huh.

MR. BUYER. Dr. Greenberg, have you seen this?

DR. GREENBERG. Yes.

MR. BUYER. I noticed on number four, that with regard to the steering committee, you are supposed to have coordinated a communication plan for dealing with outside groups. Has that plan been developed yet?

MR. MORELAND. Yes, in one of our meetings, we actually put together a two-page, I believe it was, discussion point about how to communicate and like I mentioned earlier, that plan basically instructed all of us on the group and our staff about how to communicate where we are right now. And that is, like I said earlier, probably not as fully developed as it will be soon, but it did discuss going out and communicating.

MR. BUYER. So it would be the goal that two parties are working

in collaboration and it is not yet clearly defined, so that both parties have mutual trust in good faith and the two of you work cooperatively in reaching out to the community at large. Would that be accurate, the spirit of this memorandum?

MR. MORELAND. Yes.

MR. BUYER. Dr. Greenberg, is that your understanding?

DR. GREENBERG. Yes, absolutely.

MR. BUYER. All right. So if an invitation came from whoever, that the two of you would make an appearance together -- or if not the two of you, you would try and make sure that the views are equally reflected.

MR. MORELAND. I am not sure if I will respond to exactly the question, I'm trying. The intent was to make sure the communication is the same, not that we would be together at all times.

MR. BUYER. I understand that.

MR. MORELAND. Okay.

MR. BUYER. I understand that. I guess the reason I make that point is that I am pretty much aware that some have some concerns, some are antagonistic because they disagree with what is going on here, and some perceptions were created in the veterans' community, not as a whole, but in a small piece. And it is very unfortunate, because how can something not yet defined be delivered. So you end up with inaccurate perceptions.

So I want to make sure I ask the questions on how we deal with our stakeholders, and I think that is extremely important. And I think that our Ranking Member also recognizes that by his question.

Mr. Mountcastle, I want to make sure that you still agree with this statement. At the ceremony that opened this facility, you said "It is hard for individual entities to build separate buildings, but focusing on a team research approach and the competition for research dollars, the biggest players will find the biggest strength in collaboration." You said that. Do you still believe that? You said that back in 1996. Do you still believe that today?

MR. MOUNTCASTLE. Yes, I do.

MR. BUYER. Oh, excuse me, when did you say this? 2003. Do you still believe that today?

MR. MOUNTCASTLE. Yes, I do.

MR. BUYER. Okay. Let me ask about labs for a second. I hate to jump into the weeds, I know all of you are doing this.

Mr. Moreland, what are you doing in Pittsburgh that is helpful -- as you take the Pittsburgh overlay and introduce that to Dr. Greenberg, how is that helpful to him? If you take your overlay and his overlay, what do you see?

MR. MORELAND. Well, what I have been working with Dr. Greenberg about is looking at successful ventures in other places, like Pittsburgh, but there are multiple other places where there are examples;

not necessarily as a model to move here, but as an example of success. We have talked about taking examples of success, and as you mentioned, use those to build a synergy for even better success.

So, for example, there have been situations where the VA Pittsburgh and there are others like that, has bought high-tech, high-cost equipment, retained ownership of that piece of equipment but placed it into another organization's building like a university or even a private community hospital, having that community hospital operate, maintain and use that equipment. Veterans always get preference to get to that piece of equipment but we use a piece of that volume, as Dr. Greenberg described, we use a piece of that volume. In exchange for the use of that equipment, I would get free services from that entity. So for example, place a PET scan into the University of Pittsburgh, I get free PET scans for the life of the equipment, but the University of Pittsburgh gets to use the excess capacity and they use that for their patients and their revenue generation. It is a win-win for me because I do not have the operational costs and the maintenance costs of that piece of equipment; yet, I am getting a reduction to my operating expenses by getting free PET scans. It is a win-win for the university because they get a piece of equipment that they did not have to spend $2 million to purchase, but they are able to give me the free scans because using that excess capacity allows them to generate additional revenue. So each of us wins.

So what we talked about is doing things like that and even bigger things, but that is an example. So we are prepared to move forward on some of these smaller things as proof of concept, to show that, yes, it can work; yes, it can be a good thing for veterans, be a good thing for the community. I am glad you mentioned the community. I did another arrangement with a private community hospital, they did not have the funds to purchase high-tech equipment, we did, but they were willing to run it, so by VA purchasing and maintaining ownership and placing it in the community hospital, it improved health care for the entire community, plus veterans.

So that is the kind of thing that we have been talking about doing and getting down and doing our figuring. MUSC now will work with me to talk about what volume of services they can provide to the VA at no cost or dramatically reduced cost in exchange for the use of that piece of equipment. That is the details that we are getting involved in discussing now.

MR. BUYER. If I may, Mr. Brown, Mr. Mountcastle, how much approximately in services do you presently purchase from MUSC?

MR. MOUNTCASTLE. About $13.5 million, not counting the residency costs.

MR. BUYER. And if we are to proceed in this collaboration whereby the VA builds a facility and somehow we link it with yours, at MUSC, since VA likes to say they are the low-cost provider, are you inter-

ested in exploring what services you could purchase from the VA?

DR. GREENBERG. That is an interesting question, Mr. Chairman, because the operating assumption initially was the VA traditionally has purchased services from the university, so it has been kind of a one-way purchase agreement. What has come out of the discussions when we started comparing price is that in fact, the VA may be cheaper for certain kinds of services than the university, and since federal dollars are purchasing health care for many other patients through Medicare and Medicaid and so forth, it would be the cost-efficient thing to do to lower the overall cost by purchasing some services from the VA where they can offer them at a lower cost; and therefore, also build a larger portfolio of services that the VA is able to offer.

So I have learned in these discussions that this can be very much a two-way street.

MR. BUYER. I think that is the only way this model is going to be successful. Even in Washington, I will hear the sounds from the bureaucracy that will immediately say well, gosh, we do not want the VA to be the cash cow for the medical university, just funneling money into it. It is kind of interesting how people will throw out phrases, sort of play tennis, you know, bat it away. Sometimes people will expend more time and energy to say no, than figure out how to say yes and learn to do things better, and do things well.

So I want to thank the four of you for your work here because we have a tremendous opportunity, like the Mayor said, and I am pretty excited.

The last thing, Mr. Chairman, if I may, on labs, what do you do now? Do both of you have your own labs?

MR. MOUNTCASTLE. Yes, we do. We each have our own labs, I think we actually send some specialty lab tests out to different locations.

MR. BUYER. And what do you do in Pittsburgh?

MR. MORELAND. We do have our own lab in Pittsburgh as well.

MR. BUYER. And is this part of your discussions on how you could share some of the lab tests?

DR. GREENBERG. An example, Mr. Mountcastle just mentioned there are some tests that are now sent to the VA at great distances to be analyzed elsewhere, which could be analyzed locally, so not only is it a question of cost, but also timeliness of reporting results back.

On the other hand, some of the more routine laboratory procedures may be done more cost-effectively by the VA and so some of the Medical University work could be done by lab support from the VA. So it works both ways.

MR. BUYER. On a personnel question, by percentage how many approximately of the medical staff, doctors, interns in the VA are presently provided by MUSC on a shared agreement?

MR. MOUNTCASTLE. We have -- I think as Dr. Greenberg stated in his opening remarks, most all of our physicians do have faculty ap-

pointments at MUSC. However, you know, we do have our own funded doctors but they still participate in education and research in a collaborative way with MUSC. It would be in the high 90s, I would think.

MR. BUYER. In the high 90s percentile?

MR. MOUNTCASTLE. Ninety percent.

MR. BUYER. You have already got collaboration.

MR. MOUNTCASTLE. Absolutely.

MR. BUYER. Mr. Moreland.

MR. MORELAND. I was going to respond whose doctors they are varies on which side of the street you are on. When I pay 100 percent of their salary, I consider them my doctors, even though they have an affiliation with the university. And so what I like to say is they are our doctors, they are physicians that work on both sides of the street. And you are right, that is a very high level of collaboration and cooperation with each other.

MR. BUYER. What are your time lines, present time lines?

DR. GREENBERG. We just produced the interim report that has been entered into the record. I must say, having the date of this meeting helped dictate bringing that to conclusion. Our hope would be to have another interim report about a month from the completion of that first one and then hopefully a final report about a month later, sort of a Thanksgiving present to you, sir.

MR. BUYER. Well, Thanksgiving comes early.

[Laughter.]

MR. BUYER. The reason I say it comes early is, you know, Mr. McClain, the Commission has a construction bill that we have to deal with pretty soon and that is why I say it comes early, so we need to make sure we have some discussions on legislative recommendations. If you have got some for us, get them to us. We have some leases out there that are coming due and so we need to move on our legislation to extend those existing lease arrangements around the country. So that is why I say it is coming soon.

But if you have got any recommendations that need to be incorporated in Mr. Brown's construction bill that is coming up here real soon, please let us know.

MR. MCCLAIN. Yes, sir.

MR. BUYER. And let me thank all of you. This is a heavy lift and what you are doing, a lot of people are not going to get a chance to see. Banging it out, doing that which is difficult, and when you do that, you are doing it to improve the quality of care and the access for our veterans. Some people may not realize it because they are used to it one particular way and therefore, only want it that way. But at some point when that is explained, what this endeavor is all about, then you can enjoy the fruits of your hard labor.

Mr. Chairman.

MR. BROWN. I thank you all for coming to participate, what a great sharing experience you bring to the table. We look forward to the report.

MR. MCCLAIN. Thank you, Chairman Brown.

MR. BROWN. We will now welcome our third panel. But before we do that, let us take just an informal break.

[Pause.]

MR. BROWN. Dr. Greenberg, before we start the third panel, the Chairman had one further question he wanted to ask you, if you could come back to a mic.

Chairman Buyer.

MR. BUYER. Thank you.

Dr. Greenberg, as I understand, you have laid out a plan with regard to phases, the VA has indicated a preference for a particular phase, which was different obviously than what you had thought about, and when you have got two parties who want to work together, you want to be a good listener. You have a challenge though, do you not, because that preference is the VA would say we would like to build that facility is just right across the street here. So it is right where I parked this morning, that is your entire recreational area of your campus, right?

DR. GREENBERG. Yes, sir.

MR. BUYER. So you have a tremendous challenge in front of you, do you not?

DR. GREENBERG. Yes, sir. One of the things that really has not been mentioned this morning is in addition to figuring out what we do in a coordinated fashion, the location is also critical. There are multiple potential sites for further building. I think until we know a little bit more about (a) whether the VA will build colocated with us and (b) what they would build colocated with us, it is hard to select the particular site.

MR. BUYER. And you not going to do a VA land grab now for your rec center, are you?

DR. GREENBERG. No, sir, we are not.

MR. BUYER. You have got, as we explore this, Mr. McClain, you have got a value placed on the VA property, you have got a value placed on your rec center, all those are some things that you guys have to figure out. And at the same time, you have got some other planning that you would have to do because if you want to do this, you are going to have to go out and build that, you are going to have to duplicate that somewhere else on your site, would you not?

DR. GREENBERG. Yes, we would. And as you can tell driving around campus, there is a lot of other construction going on, so the number of such sites is quite limited at the moment. I wish the Mayor was still

here because one of the things we discussed is building a potential replacement that could serve some broader community needs as well. So I think that is an opportunity.

We were anticipating leaving that towards the end of the multiple phase construction process, because of the extra cost of replacing that facility which we estimate -- and I hasten to add this is only an estimate -- is probably about a $40 million replacement cost.

MR. BUYER. Wow, that is a lot.

DR. GREENBERG. Yes, sir.

MR. BUYER. And you are going to hold that until the end?

DR. GREENBERG. That was the plan.

MR. BUYER. If we are going to go through all this endeavor and create these centers of excellence, I do not want that to be a show stopper either.

DR. GREENBERG. I mean you have my commitment that it will not be a show stopper. Part of it is a question of timing. That facility I think was completed in 1994, so it is only about 11 years old at the moment. You know, it is a little early to be replacing it today or in the next few years, but down the road, if it is necessary to do, it is necessary to do. Charleston is an urban environment, there is very little land that is not already built on, so almost any site that you begin to look at, you have to consider is there a functional facility on it and what are the ramifications of removing it.

MR. BUYER. Thanks very much. Thank you, Mr. Chairman.

MR. BROWN. Thank you, Mr. Chairman; thank you, Dr. Greenberg.

It is always a special pleasure to welcome the next panel. We are guided by the wisdom and the input from those that matter most. We have asked two prominent and well-known veterans in this area -- Clarence Mac McGee with the American Legion, and Lyn Dimery with the VFW -- to let us know their views. And gentlemen, thank you very much for coming today. Thank you for your service to this great nation and thank you for the freedom that we enjoy to be able to hold hearings like today.

Mac, I will start with you.

## STATEMENTS OF CLARENCE MAC MCGEE, NATIONAL LEGISLATIVE COUNCIL, THE AMERICAN LEGION, AND LYN DIMERY, NATIONAL LEGISLATIVE COMMITTEE, VETERANS OF FOREIGN WARS

## STATEMENT OF CLARENCE MAC MCGEE

MR. MCGEE. Mr. Chairman, Committee members, my name is Mac McGee. My home is in Berkeley County, South Carolina.

Thank you for granting me this opportunity on behalf of my fel-

low Legionnaires of the First Congressional District. I would like to extent appreciation to South Carolina's First District Congressman Brown and the Veterans' Affairs Committee and the VA Health Subcommittee for their work on behalf of the veterans of this community, state and nation.

The concerns here today are the proposal of the merger of the Ralph H. Johnson VA Medical Center and the Medical University of South Carolina.

The American Legion is the nation's largest Veterans' Service Organization with over 2.7 million members who contribute millions of hours in volunteer work in the Ralph H. Johnson VA Medical Center and other hospitals around the nation. This financial and volunteer work in the VA Hospital in this community and in VA hospitals around the nation to our nation's aging veterans is unprecedented, making our VA system more community friendly and providing a needed service.

I have personally been a member of The American Legion for over 20 years, serving as Department Commander and on several national committees. I presently serve on the National Legislative Committee.

I am a military retiree, having served over 20 years, retiring as a senior nonCom. My service to this nation taking me to many places, including Vietnam.

For the past several years, the VAMC and MUSC have enjoyed a contractual working relationship to provide services to the veterans of this community. The VAMC working with MUSC is not a new concept, but we hope that it is a continuation and better experience to the veterans of this community and that they will appreciate a better medical care delivery system.

We are pleased to note that the Veterans' Affairs overall budget has increased 40 percent since 2000 and area anticipating future funding which will keep pace with the needs of the growing and aging veteran population.

A local result of the latest Congressional Supplemental Appropriation, which infused monies into the nationwide VA system, locally will soon be seen in the Myrtle Beach, Beaufort and Savannah VA clinics through the addition of new administrative personnel that will allow clinical personnel to concentrate on giving medical care to veterans.

We are looking at an aging facility at the Charleston VAMC. With the uncertainty of future spending priorities forced upon our nation by terrorism and natural disasters such as Katrina, this facility will not be replaced at any time in the foreseeable future. We as veterans are pleased with any improvement in serving the needs of the veterans in our community. To many veterans, the VAMC is their only means of obtaining medical care and services. These men and

women have, in many cases, paid with their health. Our responsibility to them is a debt that cannot be paid. To give them the care that they deserve, through whatever vehicle, is the right thing to do. The proposal offered in cooperation with the Medical University of South Carolina sounds good. However, there are concerns that are most often asked by veterans and their dependents -- "Will this remain a Department of Veterans' Affairs hospital?" Maintaining the identity of that facility is important and that assurance, along with ample space to transact VAMC and veterans' business is critical as this transition goes forward and we, as veterans, want that assurance from the parties involved.

Regarding the planned VA clinic that is being constructed in conjunction with the Navy Super Clinic at the Naval Weapons Station, veterans want absolute assurance that the VA facility will not be taken over by DoD for active duty military in times of emergency or perceived emergency, to the medical detriment of veterans.

The following concerns voiced by veterans are very important:

What will be the impact on associated community outpatient clinics such as the VA/Navy Super Clinic just mentioned?

Where there is a patient load conflict between MUSC and VAMC, how will protocol be established, by whom will it be established, and who will make the decisions. Will it be a collaborative action of the Medical University and VAMC?

Will VAMC have its own pharmacy, especially to be responsive to known and growing outpatient needs?

How will VA co-pay and third party billing be affected?

Will the new MUSC-VAMC relationship improve the delivery of timely medical care? At present, the waiting time at the VA hospital is excessive.

Will VAMC retain its current 83 resident positions?

Will the supervising physician be Board certified at the VA? This question arises often.

The final proposal must constitute a substantial improvement over the service currently provided the veterans from the low country. Current VAMC Charleston contracts with MUSC for specialty services at approximately, I was given $17 million annually. Have we been getting our money's worth to date? How will there be a measured improvement to VA patients served as a result of this merger?

Charleston VAMC has greater experience in providing care to veterans and represents a familiarity that we do not want to lose if the two are merged. The fear is that VA will be swallowed up by the much bigger medical facility and lose its personal touch with the veterans. Will the present VA staff be incorporated in such a manner that their experience will continue to convey to their VA patients?

Our local veterans are apprehensive that services will be reduced and health care needs unmet.

As the spokesman for the American Legion and the veterans of this community and my community, we insist that the proposed merger provide all that is included in an improved level of health care to our low country veterans who have borne the battles that have given us this great nation and our freedom that we enjoy, who now suffer the consequences of their service.

Thank you.

MR. BROWN. Thank you, Mr. McGee.

Mr. Dimery.

[The statement of Clarence McGee appears on p. 136]

STATEMENT OF LYN DIMERY

MR. DIMERY. Mr. Chairman, good morning to you and your committee.

First, let me thank you for allowing me to speak here today to present the Committee with some questions from my fellow veterans on the proposed collaboration of the Ralph H. Johnson VA Medical Center and the Medical University of South Carolina.

My name is Lyn Dimery. I was born and raised in Horry County, in the town of Aynor, South Carolina.

I joined the United States Air Force after high school and retired after 21 years as a non-Commissioned officer, NCO.

I served in Vietnam for 20 months which gave me my eligibility to join one of the greatest and oldest wartime veterans organizations in the United States, the Veterans of Foreign Wars of the United States of America, VFW, and on the 29th of this month, we will celebrate our 106th anniversary.

Our membership is over 1.7 million and 700,000 in our Ladies Auxiliary. In the year of 2004, comrades and ladies had over two million hours of volunteer service in our communities, the VA hospitals, local hospitals, nursing homes and clinics.

Our organization has been serving the veterans and their families for a long time. Our motto is "Help the dead by serving the living."

I have been a member of the Veterans of Foreign Wars of the United States of America for 25 years. In the year 2000, I had the honor of being elected State Commander of our 18,000 members of the Veterans of Foreign Wars of the United States in South Carolina.

I served the past two years on the National Council of Administration of the Veterans of Foreign Wars of the U.S. I was appointed to the Legislative Committee this year by our Veterans of Foreign Wars Commander in Chief.

I have been working with veterans, active duty service personnel and their families for the past 25 years. During this time, I have heard a lot of complaints and concerns from veterans and their biggest concern is veterans' health care.

I am here today to present some questions from veterans who use this center, that concerns them on the collaboration of the VA Hospital and MUSC.

With your permission, I would like to present them at this time and hopefully see them addressed in this process.

A. Is this a sharing agreement?

B. Who is in charge, VA or MUSC?

C. Who is paying for all this and will MUSC pay their share?

D. Who gets priority, veterans or civilians?

E. How will returning veterans from Iraq and Afghanistan, will they be cared for and what priority will they get?

F. Will this VA Medical Center lose its name or its identity?

G. How will community-based outpatient clinics be affected by this collaboration?

H. How will veterans who are currently being seen in community-based outpatient clinics, who require surgery or inpatient treatment, be affected?

Mr. Chairman, thank you and your Committee for your time and allowing me to be here and present some of our fellow veterans' concerns on an important issue as this is to all veterans who use this VA Medical Center.

Thank you and God bless our veterans.

[The statement of Lyn Dimery appears on p. 140]

MR. BROWN. Thank you and thank you too, Mac, for coming and being part of this.

We have got the ear of all the people that are involved in this collaboration and so I am sure they were taking notes to answer those concerns that you might have.

My next question I guess would be to both of you is what is the best way for the facilities to communicate to the most important stakeholders as their work continues?

I know you would like to get answers to these questions, but what other dialogue could we generate within the veterans community that you would feel that you would be a part of the stakeholders and part of community group?

MR. MCGEE. I think it would be helpful if our State Commander and those folks as far as the Legion was concerned were contacted and they, through our communications, came right down to our district and to our community. The only concerns that I have heard from veterans, and I talk to hundreds of veterans a month, is essentially the same thing that both of us have asked, who is going to be in charge, how is it going to affect care that veterans receive at the VA Hospital. I think if it went through our state, they could disseminate it and more veterans would be exposed to it.

MR. BROWN. Okay.

MR. DIMERY. I agree with that. In the VFW, like the Legion, we have a commander and he is in Columbia. We have nine districts, although they are not in the low country, and if the state headquarters gets this information, they could give it to all of the nine commanders that we have and then they are responsible for getting that information out to the districts. We have not gotten much information on this.

MR. BROWN. As you might have gleaned from being at this hearing today, it is very preliminary and what we are trying to do is to find out areas we can best collaborate services. So I do not guess they have much information to communicate at this point, but we recognize as we move forward that it has got to be very important that you have a voice in this because you are the stakeholders. We are doing this for you all, we are doing it because we want you all to have better quality health care. Not just the ones in this room, but those young men and women that are coming back with some very trying times and they are going to have to live with one arm or one leg. I was up in Bethesda about two months ago and had my appendix taken out but I was on the fifth floor with a lot of those young men that were coming back, and prosthesis is a big item because a lot of them are coming back with a lot of parts missing. And so the challenges that we face with health care in the 21st century is going to be different from what we had in the 20th century. So that is the reason we are looking for better ways to deliver this health service.

But I do appreciate you all coming and being a part of this.

Mr. Michaud, do you have questions?

MR. MICHAUD. First of all, I would like to thank both of you for your service to our nation and also for the advocacy for our veterans as well. I really appreciate that.

You have raised several good questions here today and I am sure there will be probably additional questions as time moves on. And I know last week, the American Legion presented its legislative agenda to the Joint Session of the House and Senate Veterans' Affairs Committee and one key issue that actually they raised was about the stakeholders' input on ongoing CARES studies and I know that is a key issue with the VFW as well.

I do know the VA has set up local advisory panels for all of the ongoing CARES facility studies. Do you think that would be helpful in this process as well, is my first question. My second question is I know there are more organizations than American Legion and VFW. Does South Carolina have a -- in Maine, we have what we call a Commanders Call, the Maine Veterans Coordinating Committee for all the VSOs. The commanders will get together and there is one individual who is the head of that that actually helps coordinate and disseminate that information. Do you have such a group here?

MR. MCGEE. I do not think so, but we should have.

MS. MILLING. Yes, we do. We have an Advocacy Council. The state commanders of the service organizations get together. The meeting is usually called by the Director of the State Veterans' Affairs Office.

MR. MICHAUD. Thank you.

Like I said, I thought you had a lot of good questions and you heard Mr. Greenberg mention this morning and in his written testimony that he values his relationships with veterans and I think that value should not only take care of veterans when you are in the hospital, but before. And hopefully they will include you up front versus near the end, because I think any time we can get the information out there, if you have questions. That synergy and collaboration that we talked about earlier this morning is very crucial. And I think probably some of the opposition and concern out there is just that you do not know the answers and I am in hopes that the committee will look at that and really make you part of that process and I assume that you are willing to participate in that process.

MR. MCGEE. Yes, sir.

MR. DIMERY. Yes, sir. I think you are very right there. That would stop the rumors because right now it is all rumors and you know how you get rumors started, and if we get more information, we could pass it out at our meetings, like American Legion at VFW, we have conferences, conventions and we have CFAs every month and we could pass this on, which I will be passing this on this Sunday, the information I have got. That will help us a lot.

MR. MICHAUD. I agree.

That is all I have, Mr. Chairman, and again, I do want to thank you for your strong advocacy for veterans and for having this hearing here. It is so important.

MR. BROWN. Thank you, Mr. Michaud, and I am grateful that we are able to serve, this is our third year now with the Chairman and Ranking Member and we have a great relationship. We usually say in Washington that partisan politics stops at the Committee room door. Veterans issues is not about Republicans and Democrats, it is about health care and benefits. And this is what we are about and I am grateful that we have that great relationship.

And for the lady who stood up, I would like for you, if you do not mind, stand back up and give your name so we can have record of your input.

MS. MILLING. My name is Alta Milling. I am the State Council President of the Vietnam Veterans of America.

MR. BROWN. Thank you very much.

Mr. Chairman, do you have a question?

MR. BUYER. You know, Sergeant Major, Master Sergeant, if you look back on our military history, it must have been one heck of a decision when they decided to take the Army Air Corps out of the Army to create the Air Force.

[Laughter.]

MR. MCGEE. Yes, sir, messed up everything.
[Laughter.]

MR. BUYER. Now when you go past the humor, the Marine Corps said no, they wanted to maintain their own air assets, they wanted their pilots and the crew to sweep and to know exactly who the ground pounders were. So when I call in fire or you have got to call in fire, I know you, we know each other. I am bringing it in as close as I can and I will be damned if it is going to hit you and you are going to feel comfortable I can bring it in without hitting you.

MR. MCGEE. I always felt comfortable.

MR. BUYER. Some guys do not necessarily feel comfortable when it is an F-15 flying that fast, they say do not worry about it, I can hit them and not hit you.

I guess I am really after the word "synergies", synergies and trust and what we feel comfortable with and you can deliver things finally and that is invaluable, right?

MR. MCGEE. It is.

MR. BUYER. Now we are talking about in life. How do you create synergies and make it timely and deliver so it has a real impact on people. That is what this is about.

MR. MCGEE. I think information.

MR. BUYER. And that is what this is about.

MR. MCGEE. Information is the key.

MR. BUYER. I think that is true. I think the questions that both of you asked after you met with your veterans were very good questions that anybody would ask when you are on the outside not knowing.

The good thing about Chairman Brown asking us to come down here and have this hearing is that this information can get out at the same time we give input with regard to ongoing negotiations and discussions. There is nothing easy about what is happening here. We want it to be hard and we want it to be difficult because we know that if they are successful and can build this model and create these new synergies, that we improve quality. That is the goal. And I think that is pretty exciting.

And I wrote down all the questions you asked quickly as you were asking them, and immediately just clicking off in my head, most of these you got answered here today.

MR. MCGEE. That is true.

MR. BUYER. So you are able to go back to your comrades and let them know what you have heard here today. At the same time, you also know that Dr. Perlin issued a memorandum whereby the steering group is to formulate how to communicate with all of you. So hopefully in a timely manner that can be done.

I noticed you had a question, Sergeant Major, on how will there be measurement for improvement. Sounds like the GAO.

[Laughter.]

MR. BUYER. That is exactly what the GAO's testimony was about. And so Sergeant Major, you hit it right on the head. The same demands that you made over the years in command leadership, the element that makes the difference, is the same thing that GAO has been invited to do by Chairman Brown, to create those measurements. So when Mr. McClain testified about the five-year plan and how we measure it, we do not know if that is the proper measurement, because that is for different types of models.

MR. MCGEE. Right.

MR. BUYER. So how are we going to properly measure success? I do not know, but I am willing to work with them to figure out how to do it. And there are going to be some hurdles that we have to overcome. You know, there are some concerns that the VA may have and there are some definite concerns that MUSC has got to have. They just built a rec facility and all of a sudden the VA goes yeah, but I want this property, not that property, we will give you this but you have got to build something somewhere else. These are big chess pieces, okay, that we are moving across the pavement here. And it all has to be done so that it is mutual, right? You have got trust, it makes sense for the taxpayer, but more importantly it makes sense for the customer. And for that customer, I will share with you that I believe that Dr. Greenberg has an equal desire to provide quality services as Mr. Mountcastle has in providing them to the VA customers.

So how do we create the synergy whereby we continue to improve. And this is pretty exciting when you can combine some of the greatest minds in the country that are here, to do that. Too often, we think the expert is in Columbia or is in Charlotte and you have got to go somewhere else to look for it. But you know what? We have got it right here and so I am very impressed by the staff that I have worked with. You have got the best in the country, Dr. Greenberg, and creating these synergies for excellence for Charleston, South Carolina to lead the country in a model that is being leveraged -- I will go back to the word pride.

So Mr. Chairman, thank you for your efforts and I want to thank my comrades in the Veterans Service Organizations for not only your service but your work in caring for the veterans who cannot care for themselves. Thank you, and God speed to all of you.

MR. MCGEE. Thank you.

MR. BROWN. Thank you, Mr. Chairman.

I too would like to extend my appreciation to both of you for your leadership in the veterans' community and I look forward to continuous dialogue.

This has been a great sharing experience today. We have got a lot of good information. There certainly are a lot of dedicated people involved in trying to make life better for our veterans.

With that, this meeting stands adjourned.

[Whereupon, the Subcommittee was adjourned at 11:32 a.m.]

# APPENDIX

**OPENING STATEMENT**

**HONORABLE HENRY E. BROWN, JR.**
**CHAIRMAN, SUBCOMMITTEE ON HEALTH**
**COMMITTEE ON VETERANS' AFFAIRS**

**Hearing on Collaborative Opportunity for the Charleston (Ralph H. Johnson) VA Medical Center (VAMC) and the Medical University of South Carolina (MUSC) to Share Facilities and Resources**

**Charleston, South Carolina**
**September 26, 2005**

Good morning.

This is a hearing of the Subcommittee on Health, Committee on Veterans Affairs. We will come to order.

As Chairman of the Subcommittee on Health, I am very pleased to be joined today by both our distinguished Chairman of the House Veterans Affairs Committee, Steve Buyer from Indiana's Fourth district and the Subcommittee's Ranking Democratic Member, the Honorable Michael Michaud.

Mr. Chairman, I am truly honored to have you with us this

morning and I especially appreciate your strong leadership and willingness to work with the Subcommittee on this very important matter. Your persistent efforts have already proven instrumental in bringing VA and MUSC together in order to advance discussions on collaboration. And for that, I thank you.

It is also a real pleasure to have my friend and the Subcommittee's Ranking Member, Mike Michaud, here in the low country. Mike and I shared a leadership role last year on the Benefits Subcommittee. This year, as I was selected to Chair the Health Subcommittee, Mike was designated as the Ranking Member on Health. I think we have a very strong working relationship and I was honored to join him recently in his beautiful home state of Maine. Now, its South Carolina's chance to return the hospitality we were shown by Mr. Michaud and his staff. Welcome Mike and thank you for joining us today.

I would like to remind everyone here today, that our purpose is simple: We are here to conduct an official congressional hearing examining

opportunities for enhanced collaboration between VA and MUSC. I understand there will be some in the audience who will be hesitant to embrace the idea of collaboration here, but we want to hear from the experts as to whether or not collaboration can be expanded. To that end, I would remind you-- because this is an official hearing-- there will not be opportunities for members of the audience to speak. There will be plenty of time for that and in fact, I plan to host a number of public meetings here in Charleston, to hear your questions, concerns and hopefully your support once the information is shared in today's official format.

My goal as the Chair of the Subcommittee on Health is to improve the health care delivery for our veterans and keep it in step with the 21st Century. Most importantly, I am deeply committed to doing what is right for the veterans of South Carolina. And to that end, I have worked hard to ensure that the veterans in this state are able to access the best and most timely care at a location that is closer to their homes. I have worked to expand the Community Based Outpatient Clinic in Myrtle

Beach. Dedicated in March of this year, the new clinic is more than double its original size, going from 4,200 to 12,800 square feet. It includes 16 primary care examination rooms with the capability to be expanded for 24 rooms, as needed. The $2.75 million project also includes on-site digital x-ray equipment and 36 additional parking spaces.

We can also look forward to the new outpatient clinic that is to be built on the Naval Weapons Station in Goose Creek which is targeted for opening in 2008. In the meantime, however, on September 13, VA opened a temporary North area VA outpatient facility on the TRIDENT Medical center complex.

Here in Charleston, we have a unique and wonderful opportunity to develop a new and innovative model for delivering the highest quality health care to our veterans and set the standard for all other areas to follow.

VA and MUSC have a long-standing and strong history of working collaboratively. Facilitated by their physical proximity to each other, the two medical facilities already share significant amounts of medical staff and research activities. In fact, some 243 physicians who hold faculty appointments at MUSC now treat veteran patients at VA Medical Center. Of those, about 125 to 150 do so on a regular basis, along with another 85 MUSC Residents at any given time. This represents over 95% of VA's physician staff at the hospital.

Nine years ago, Senator Thurmond took the lead and was instrumental in creating the building where we are holding our hearing today. The Thurmond/Gazes Biomedical Research Center is shared by the VA and the Medical University and houses the research efforts of both institutions. It is widely acclaimed as a highly successful model that has served to set a national precedent in the area of collaboration.

In addition to the existing relationship in research, VA and MUSC are already engaged in a significant effort in the area of clinical services. In

fact, the VA medical center currently purchases roughly $13 million in specialty medical services. The relationship exists, now we want to see if it can be expanded in order to improve care and at the same time, reduce the need for BOTH organizations to purchase expensive, duplicate equipment and infrastructure. All of these factors make this an ideal time to further explore such an option. And that's what we are doing—exploring.

I want to assure all of you here today, especially all the local Veterans' Service Organizations that are so important to the process, that this is NOT about VA losing control of the care for veterans or destroying VA's ability to meet veterans' unique needs. It is about advancing an already successful partnership in order to provide the veterans of South Carolina the highest quality of specialized inpatient care in the best and most up-to-date facilities. The bottom line is: we are not interested in collaboration for collaboration's sake, we are interested in improving the clinical services provided to veterans through new and innovative delivery models.

I am confident that the panels we have assembled here today will help us better understand how a mutually beneficial collaborative agreement can be crafted and how the many complex and critical issues can be effectively worked out.

I now yield to Mr. Michaud to make an opening statement.

Thank you, Mr. Michaud.

I now yield to Chairman Buyer to make an opening statement

Thank you, Mr. Chairman

Panel 1

Let's now begin.

On our first panel we have Mr. Mark Goldstein. He is a director of Physical Infrastructure Issues at the U. S. Government Accountability Office. The Committee has requested GAO, the agency responsible for reviews and investigations in federal property, to examine the issues surrounding the opportunity for VA and MUSC to enter into a joint venture and provide the Committee with a report and recommendations.

Mark, please begin when you are ready.

Thank you, Mr. Goldstein. We appreciate your efforts to date and all the continued hard work of GAO to complete your review.

Panel 2

Our second panel consists of officials from the Department of Veterans Affairs and the Medical University of South Carolina.

Representing VA is the Honorable Tim S. McClain, VA's General Counsel. He serves as the chief legal advisor to the Secretary and the Department. In January 2005, Secretary Nicholson designated Mr. McClain as the interim Chief Management Officer (CMO). As CMO, Tim is also responsible for among other things, the Department's finance policy and operations and real property asset management policy.

Dr. Raymond S. Greenberg became the eighth President of the Medical University of South Carolina in 2000. The author of about 150 scientific publications, Dr. Greenberg is nationally recognized for his research on cancer and he has served on many national scientific advisory boards.

Welcome and please proceed.

Panel 3

Let us now welcome the next panel. Our priorities are guided by the wisdom and the input from those that matter most and we have asked

two prominent and well-known veterans in this area, Clarence "MAC" McGee with the American Legion and Lyn Dimery with the VFW to let us know their views.

I thank each of you for what you do for our Nation's veterans and for being here today.

This hearing of the Subcommittee on Health is adjourned.

# Opening statement for Chairman Buyer Statement
# Charleston Field Hearing
# September 26, 2005

Good morning. I am glad to see that there is a high level of interest in this initiative, because improving how we deliver health care to veterans here and across the nation is important. I think everyone here would agree that health care is becoming the most important issue in our lives.

I would like to personally thank Chairman Henry Brown, who has been an invaluable member of the Veterans' Affairs Committee, for holding today's hearing and inviting me to be a part of it. South Carolinians, and particularly the veterans of South Carolina, have a real champion in Henry Brown. Henry, I thank you for both your continued hospitality and your hard work on behalf of this nation's veterans.

I also want to thank VA's general counsel, Tim McLain, for his involvement on behalf of Secretary Nicholson. I also thank Mr. Mountcastle, Dr. Ray Greenberg, and their respective teams of dedicated professionals for their interest in the welfare of the veterans at Charleston and for their willingness to consider the possibilities that sometimes controversial new ideas can generate.

One of the major concerns of veterans here I believe is the concern that they are about to "lose their VA hospital" to the university. That the university wants to "grab" land. I think those words may have been used. Based on what we are trying to accomplish here, I think those words are simply misplaced.

Fellow veterans, the University of South Carolina already has a solid relationship with The Johnson VA Medical Center. The proposal we are considering and will hear about today seeks to increase the cooperation we already have with a very capable university medical system.

If that benefited you, the veterans, would that be worth considering? — just *considering*, now, not jumping into it without a good look — would that not be worth a little reconnaissance?

One of the terms you hear a lot of is "cutting edge." I think that term has been used to promote the relationship with MUSC. It's not an empty phrase.

It means that veterans will get state-of-the-art, quality care faster — in minutes instead of hours or days. If I'm waiting for surgery, I prefer minutes. Don't you?

Now, every time the subject is changing how the federal government does business, you see hesitation, anxiety; you hear all the reasons "why not." You hear that one group is trying to get the better of the other group; someone's trying to move my cheese. I ask you to think beyond that — don't lose your vigilance — but think about what can be.

I just ask everyone in this room to look around them and consider what you see. I see a shared VA/MUSC research facility that serves as a guidepost for other VA medical centers around the country.

This project can demonstrate how stronger relationships can be built with existing, medical school affiliates, without exploiting or weakening *your* VA.

It is usually not easy for federal agencies to envision change. Unfortunately, we on the VA committee have seen opportunities like the one here in Charleston come . . . and go. Meanwhile, waiting times go up and the U.S. sees a bigger shortage of young men and women attending medical school every year. Resources are not on the side of isolated facilities, ladies and gentlemen.

So, I invite you today to seriously consider the possible; consider what can be done for veterans.

I look forward to continuing to work with Chairman Brown and all of you here today to ensure that this dialogue goes well beyond today's hearing and your final October report. As Chairman, I will lend whatever assistance to Mr. Brown I can, because I think this effort makes sense for the veterans in this room and the veterans who will follow after you in the decades to come.

Thank you for your service.

United States Government Accountability Office

GAO

Testimony

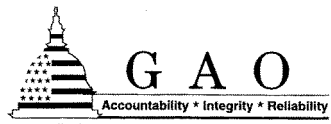
Before the Subcommittee on Health, Committee on Veterans' Affairs, House of Representatives

For Release on Delivery
Expected at 9:00 a.m. EDT
in Charleston, S.C.
Monday, September 26, 2005

# VA HEALTH CARE

# Preliminary Information on the Joint Venture Proposal for VA's Charleston Facility

Statement of Mark L. Goldstein, Director
Physical Infrastructure Issues




GAO-05-1041T

GAO
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Highlights

Highlights of GAO-05-1041T, a testimony before the Subcommittee on Health, Committee on Veterans' Affairs, House of Representatives

## Why GAO Did This Study

The Department of Veterans Affairs (VA) maintains partnerships, or affiliations, with university medical schools to obtain medical services for veterans and provide training for medical residents. In 2002, the Medical University of South Carolina (MUSC)—which is affiliated with VA's medical facility in Charleston—proposed that VA and MUSC enter into a joint venture for a new VA facility as part of MUSC's plan to expand its medical campus. Under the proposal, MUSC and VA would jointly construct and operate a new medical center in Charleston.

In 2004, the Capital Asset Realignment for Enhanced Services (CARES) Commission, an independent body charged with assessing VA's capital asset requirements, issued its recommendations on the realignment and modernization of VA's capital assets. Although the Commission did not recommend a replacement facility for Charleston, it did recommend, among other things, that VA promptly evaluate MUSC's proposal.

This testimony discusses GAO's preliminary findings on the (1) current condition of the Charleston facility, (2) extent to which VA and MUSC collaborated on the joint venture proposal, and (3) issues for VA to consider when exploring the opportunity to participate in the joint venture.

VA concurred with GAO's preliminary findings.

www.gao.gov/cgi-bin/getrpt?GAO-05-1041T.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Mark L. Goldstein (202) 512-2834 or goldsteinm@gao.gov.

September 26, 2005

# VA HEALTH CARE

# Preliminary Information on the Joint Venture Proposal for VA's Charleston Facility

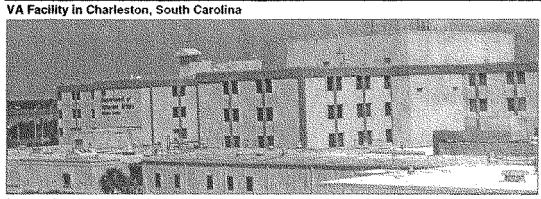
## What GAO Found

The most recent VA facility assessment and the CARES Commission concluded that the Charleston medical facility is in overall good condition and, with some renovations, can continue to meet veterans' health care needs in the future. VA officials attribute this to VA's continued capital investments in the facility. For example, over the last 5 years, VA has invested approximately $11.6 million in nonrecurring maintenance projects, such as replacing the fire alarm system and roofing. To maintain the facility's condition over the next 10 years, VA officials from the Charleston facility have identified a number of planned capital maintenance and improvement projects, totaling approximately $62 million.

VA and MUSC have collaborated and communicated to a limited extent over the past 3 years on a proposal for a joint venture medical center. For example, before this summer, VA and MUSC had not exchanged critical information that would help facilitate negotiations, such as cost analyses of the proposal. As a result of the limited collaboration, negotiations over the proposal stalled. However, after a congressional delegation visit in August 2005, VA and MUSC took steps to move the negotiations forward. Specifically, VA and MUSC established four workgroups to examine critical issues related to the proposal.

The MUSC proposal for a new joint venture medical center presents an opportunity for exploring new ways of providing health care to Charleston's veterans, but it also raises a variety of complex issues for VA. These include the benefits and costs of investing in a joint facility compared with other alternatives, legal issues associated with the new facility such as leasing or transferring property, and potential concerns of stakeholders, including VA patients and employees. The workgroups established by VA and MUSC are expected to examine some, but not all, of these issues. Additionally, some issues can be addressed through collaboration between VA and MUSC, but others may require VA to seek legislative remedies.

**VA Facility in Charleston, South Carolina**



Source: GAO

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here in Charleston to provide our preliminary findings on the possibility of the Department of Veterans Affairs (VA) and the Medical University of South Carolina (MUSC) entering into a joint venture for a new medical center in Charleston. For decades VA has developed and maintained partnerships, or affiliations, with university medical schools to obtain medical services for veterans and provide training and education to medical residents. Today, VA has affiliations with 107 medical schools. These affiliations—one of which is with MUSC—help VA fulfill its mission of providing health care to the nation's veterans. For example, many MUSC physicians serve as residents at VA's medical facility in Charleston, the Ralph H. Johnson VA Medical Center. This medical facility is an important part of the VA health care network, providing over 4,000 inpatient stays for veterans in 2004.

To provide health care to veterans, in part through partnerships with university medical schools, VA manages a diverse inventory of real property. VA reported in February 2005 that its capital assets included more than 5,600 buildings and about 32,000 acres of land.[1] However, many of VA's facilities were built more than 50 years ago and are no longer well suited to providing accessible, high-quality, cost-effective health care in the 21st century. To address its aging infrastructure, VA, in 1999, initiated the Capital Asset Realignment for Enhanced Services (CARES) process—the first comprehensive, long-range assessment of its health care system's capital asset requirements in almost 20 years. In February 2004, the CARES Commission—an independent body charged with assessing VA's capital assets—issued its recommendations regarding the realignment and modernization of VA's capital assets necessary to meet the demand for veterans' health care services through 2022. For example, the Commission recommended replacing VA facilities in Denver and Orlando. The Commission did not recommend replacing the VA facility in Charleston, which is a primary, secondary, and tertiary care facility.[2] However, the

[1]Department of Veterans Affairs, *5-Year Capital Plan 2005-2010* (Washington, D.C.: February 2005).

[2]Primary care is defined as health care provided by a medical professional with whom a patient has initial contact and by whom the patient may be referred to a specialist for further treatment. Secondary care is provided by a specialist or facility upon referral by a primary care physician that requires more specialized knowledge, skill, or equipment. Tertiary care is highly specialized medical care, usually over an extended period of time, that involves advanced and complex procedures and treatments performed by medical specialists in state-of-the-art facilities.

Commission recommended that, among other things, VA promptly evaluate MUSC's proposal to jointly construct and operate a new medical center with VA in Charleston, noting that such an arrangement could serve as a possible framework for partnerships in the future. In responding to the Commission's recommendations, the Secretary stated that VA will continue to consider options for sharing opportunities with MUSC.[3]

My statement today will cover the (1) current condition of the Charleston facility and the actions VA has taken to implement CARES recommendations at the facility, (2) extent to which VA and MUSC collaborated on the proposal for a joint medical center, and (3) issues for VA to consider when exploring the opportunity to participate in the joint venture. My preliminary comments are based on our ongoing work for the full Committee as well as GAO's body of work on VA's management of its capital assets.[4] For our ongoing work, we interviewed VA and MUSC officials as well as other stakeholders in the Charleston area, including officials from the City of Charleston and the U.S. Navy. We also reviewed the CARES Commission's comments on and recommendations for the Charleston facility; documents relating to the MUSC proposal, including correspondence between MUSC and VA; federal statutes; and past GAO reports. We obtained comments on this testimony from VA and MUSC officials, which we incorporated as appropriate. We conducted our work from June through September 2005 in accordance with generally accepted government auditing standards.

In summary:

- The most recent VA facility assessment and the CARES Commission concluded that the Charleston facility is in overall good condition and with some renovations can continue to meet veterans' health care needs in the future. VA officials attribute the facility's condition to VA's continued capital investments. For example, over the last 5 years, VA has invested approximately $11.6 million in nonrecurring maintenance projects, such as replacing the fire alarm system and roofing. The CARES Commission did not recommend replacing the Charleston facility; however, the Commission recommended renovations of the nursing home care units as well as the inpatient wards in order to meet the needs of the projected

[3]Department of Veterans Affairs, *Secretary of Veterans Affairs: CARES Decision* (Washington, D.C.: May 2004).

[4]See "Related GAO Products" at the end of this testimony.

veterans' population in the Charleston area. The CARES projections indicate that demand for inpatient beds at VA's facility in Charleston will increase by 29 percent from 2001 to 2022, while demand for outpatient services will increase by 69 percent during the same period. To maintain the facility's condition over the next 10 years, officials from the VA facility in Charleston have identified a number of planned capital maintenance and improvement projects, including repairing expansion joints, making electrical upgrades, and adding a parking deck for patients. VA officials estimate that the costs of these planned maintenance and improvement projects will total about $62 million.

- VA and MUSC collaborated and communicated to a limited extent on a proposal for a joint venture medical center over the past 3 years. In November 2002, the President of MUSC made a proposal to the Secretary of VA to participate in a 20-year, multiphase construction plan to replace and expand its campus. Under MUSC's proposal, MUSC would acquire the site of the current VA facility in Charleston for part of its expansion project and then enter into a joint venture to construct and operate a new facility on MUSC property. The CARES Commission recommended that VA promptly evaluate MUSC's proposal to jointly construct and operate a new medical center with VA. Although there has been some discussion and correspondence between VA and MUSC since 2002 on the joint venture proposal, collaboration has been minimal. For example, before this summer, VA and MUSC had not exchanged critical information that would help facilitate negotiations, such as cost analyses of the proposal. As a result of the limited collaboration, negotiations over the proposal stalled. After a congressional delegation visited Charleston in August 2005, however, VA and MUSC took some initial steps to move the negotiations forward. Specifically, VA and MUSC established four workgroups to examine critical issues related to the proposal.

- The MUSC proposal for a new joint venture medical center presents a unique opportunity for VA to explore new ways of providing health care to Charleston's veterans now and in the future; however, it also raises a variety of complex issues for VA. These include the benefits and costs of investing in a joint facility compared with those of other alternatives, such as maintaining the existing facility or considering options with other health care providers in the area; legal issues associated with the new facility, such as leasing or transferring property, contracting, and employment; and potential concerns of stakeholders. The workgroups established by VA and MUSC are expected to examine some, but not all, of these issues. In addition, some issues can be addressed through collaboration between VA and MUSC, while others may require VA to seek legislative remedies. Until these issues are explored, it will be difficult to

make a final decision on whether a joint venture is in the best interest of the federal government and the nation's veterans.

## Background

VA manages a vast medical care network for veterans, providing health care services to about 5 million beneficiaries. The estimated cost of these services in fiscal year 2004 was $29 billion. According to VA, its health care system now includes 157 medical centers, 862 ambulatory care and community-based outpatient clinics (CBOC), and 134 nursing homes. VA health care facilities provide a broad spectrum of medical, surgical, and rehabilitative care. The management of VA's facilities is decentralized to 21 regional networks referred to as Veterans Integrated Service Networks (networks). The Charleston facility is part of Network 7, or the Southeast Network.[5]

The Charleston medical facility is a part of the VA health care network and has served the medical needs of Charleston area veterans since it opened in 1966. The Charleston facility is a primary, secondary, and tertiary care facility. (See fig. 1.) The facility consists of more than 352,000 square feet with 117 medical and surgical beds and 28 nursing home care unit beds; according to VA officials, the average daily occupancy rate is about 80 percent. The outpatient workload was about 460,000 clinic visits in fiscal year 2004. VA employs about 1,100 staff at the Charleston facility, which has an annual operating budget of approximately $160 million.

[5]This network encompasses an area containing VA facilities in South Carolina, Georgia, and Alabama.

Figure 1: East Side of The Ralph H. Johnson VA Medical Center in Charleston, Adjacent to MUSC Project Construction

Source: GAO

VA's Charleston medical facility is affiliated with MUSC. MUSC is the main source of the Charleston facility's medical residents, who rotate through all major VA clinical service areas. VA also purchases approximately $13 million in medical care services from MUSC, including gastroenterology, infectious disease, internal medicine, neurosurgery, anesthesia, pulmonary, cardiovascular perfusion, and radiology services. In addition, VA has a medical research partnership with MUSC for a mutually

supported biomedical research facility, the Thurmond Biomedical Research Center.

MUSC operates a 709 licensed bed acute care hospital in Charleston that also provides primary, secondary, and tertiary services. The services available through MUSC span the continuum of care with physician specialists and subspecialists in medicine, surgery, neurology, neurological surgery, psychiatry, radiology, and emergency medicine, among other specialties. During a 12-month period ending on June 30, 2003, MUSC admitted 28,591 patients (including newborns), representing an occupancy rate of approximately 78 percent of available beds. Outpatient activity for the same period included 6,802 same-day surgeries, 551,914 outpatient visits, and 35,375 emergency visits. MUSC's net patient service revenue for the fiscal year ending on June 30, 2003, was about $559 million.

## VA Determined That the Charleston Facility Is in Good Condition and Is Currently Investing in Minor Renovations

VA and the CARES Commission concluded that the Charleston facility is in overall good condition and, with relatively minor renovations, can continue to meet veterans' health care needs in the future. VA conducts facility condition assessments (FCA) at its facilities every 3 years on a rotating basis.[6] FCAs evaluate the condition of a VA facility's essential functions—electrical and energy systems, accessibility, sanitation and water—and subsequently estimate the useful and remaining life of those systems. The Charleston facility's most recent FCA was conducted in 2003, and this assessment showed that the facility currently is in overall good condition. According to VA officials, the facility's current condition is a result of targeted capital investments. In particular, VA invested about $11.6 million in nonrecurring maintenance projects over the last 5 years. Such projects include installing a new fire alarm system, replacing roofing, painting the exterior of the building, and upgrading interior lighting.

The CARES Commission did not recommend replacing VA's facility in Charleston as it did with facilities in some other locations. In assessing the capital asset requirements for the Charleston facility, the Commission relied on the 2003 FCA and projections of inpatient and outpatient service demands through 2022, among other things. These projections indicate

[6]According to VA officials, FCAs provide VA with a professional assessment of its capital assets that facilitates and enables uniformed planning and expenditure of resources. Multidisciplinary teams of architects and engineers, in conjunction with facility staff, conduct the FCAs.

that demand for inpatient beds at VA's facility in Charleston will increase by 29 percent from 2001 to 2022, while demand for outpatient services will increase by 69 percent during the same period.[7] Although the CARES Commission did not recommend a new facility in Charleston, it did call for renovating the nursing home units and the inpatient wards. In his response to the Commission's recommendations, the Secretary agreed to make the necessary renovations at the Charleston facility.

VA officials at the Charleston medical facility have a number of ongoing and planned capital maintenance and improvement projects to address the CARES Commission recommendations and to maintain the condition of the current medical center. For example, two minor capital improvements—totaling $6.25 million—are currently under construction.[8] These projects include

- a third floor clinical addition, which will add 20,000 square feet of space to the medical center for supply processing and distribution,[9] rehabilitation medicine, and prosthetics; and
- the patient privacy project, which will renovate the surgical in-patient ward to provide private and semiprivate bathrooms for veterans.

Planned capital maintenance and improvements projects over the next 10 years include electrical upgrades, renovation of several wards to address patient privacy concerns, renovation of operating rooms and the intensive care units, and the expansion of the specialty care clinics. VA officials estimate that the total cost for all planned capital maintenance and improvement projects is approximately $62 million.

In addition to the capital improvement projects at the medical center in Charleston, VA is currently constructing a CBOC, in partnership with the Navy, at the Naval Weapons Station in Goose Creek, South Carolina. The

[7]These trends are based on the original CARES workload projections for the Charleston facility. VA recently updated the CARES workload projections and the updated projections suggest different trends. Neither the original or updated projections, however, factor in the potential impact on workload of veterans returning from Afghanistan and Iraq.

[8]According to VA, minor capital improvement projects are those costing less than $7 million.

[9]Supply processing and distribution is a section of the medical center that is dedicated to the receiving, storage, and distribution of medical supplies and the decontamination and sterilization of reusable medical supplies and equipment.

new clinic will be a joint VA-Navy facility and will help VA address the projected increase in demand for outpatient services. The new clinic—called the Goose Creek CBOC—is scheduled to open in 2008 and will serve a projected 8,000 patients who are currently served by VA's Charleston facility. VA estimates its investment in the planning, design, and construction of the Goose Creek CBOC will be about $6 million.

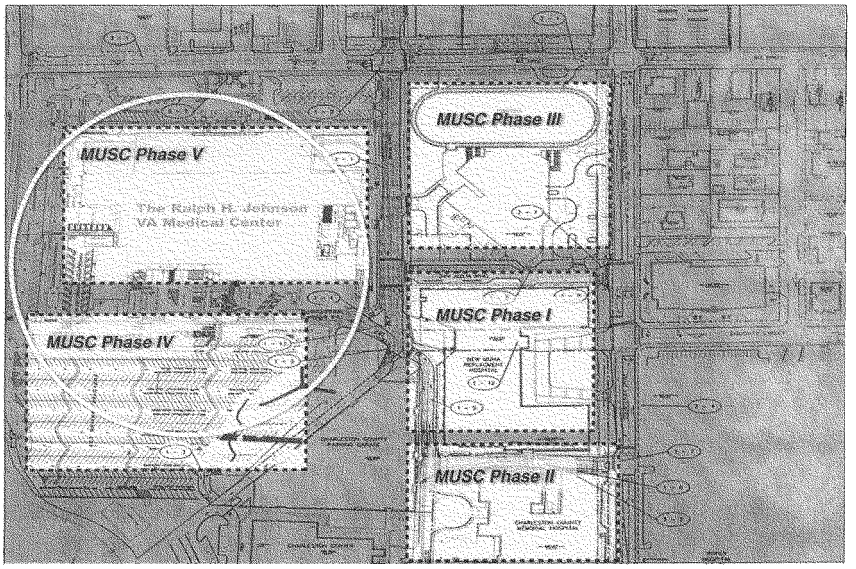
## Limited Collaboration between VA and MUSC on a Joint Venture Facility Characterized Negotiations until Recently

VA and MUSC have collaborated and communicated to a limited extent on a proposal for a joint venture medical center over the past 3 years. As a result of the limited collaboration, negotiations over the proposal stalled. In August 2005, however, initial steps were taken to move the negotiations forward. Specifically, four workgroups were created—which include both VA and MUSC officials—and tasked with examining critical issues related to the proposal.

## Limited Communication and Collaboration Have Hampered Negotiations over MUSC's Joint Venture Proposal

To meet the needs of a growing and aging patient population, MUSC has undertaken an ambitious five-phase construction project to replace its aging medical campus. Construction on the first phase began in October 2004. Phase I includes the development of a four-story diagnostic and treatment building and a seven-story patient hospitality tower, providing an additional 641,000 square feet in clinical and support space—156 beds for cardiovascular and digestive disease services, 9 operating rooms, outpatient clinics with a capacity of 100,000 visits, and laboratory and other ancillary support services. Phase I also includes the construction of an atrium connecting the two buildings, a parking structure, and a central energy plant. Initial plans for phases II through V include diagnostic and treatment space and patient bed towers. As shown in figure 2, phases IV and V would be built on VA property. In particular, phase V would be built on the site of VA's existing medical center. MUSC has informed VA about its proposed locations for these facilities. According to MUSC officials, there are approximately 2 years remaining for the planning of phase II.

**Figure 2: MUSC Construction Plan**




Source: VA

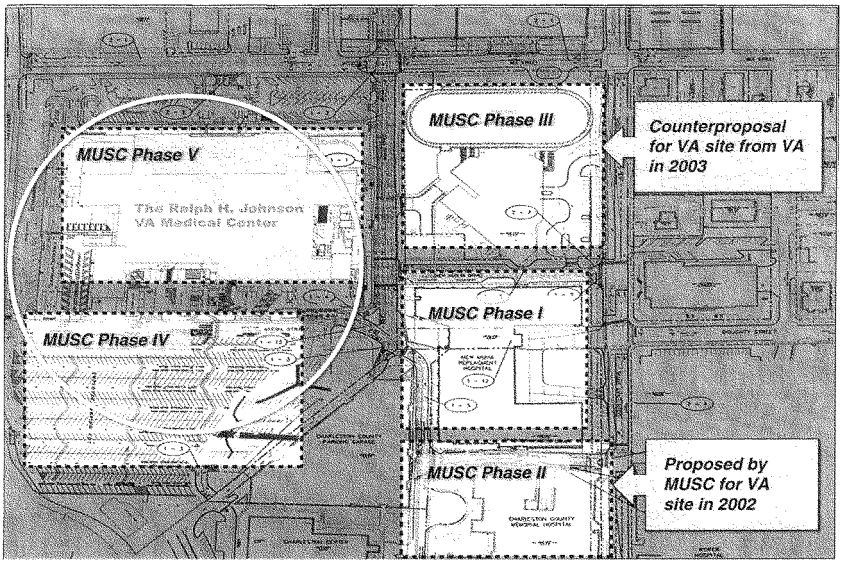
Note: The circle highlights some of VA's existing property.

In November 2002, the President of MUSC sent a proposal to the Secretary of VA about partnering with MUSC in the construction and operation of a new medical center in phase II of MUSC's construction project. Under MUSC's proposal, VA would vacate its current facility and move to a new facility located on MUSC property to the south of phase I. MUSC also indicated that sharing medical services would be a component of the joint venture—that is, VA and MUSC would enter into sharing agreements to buy, sell, or barter medical and support services. VA and MUSC currently share some services—for example, VA purchases services for gastroenterology, infectious disease, and internal medicine. According to

MUSC officials, the joint venture proposal would increase the level of sharing of medical services and equipment, which would create cost savings for both VA and MUSC. VA officials told us that the proposed joint venture between MUSC and VA is unprecedented—that is, should VA participate in the joint venture, it would be the first of its kind between VA and a medical education affiliate.

In response to MUSC's proposal, VA formed an internal workgroup composed of officials primarily from VA's Southeast Network to evaluate MUSC's proposal. The workgroup analyzed the feasibility and cost effectiveness of the proposal and issued a report in March 2003, which outlined three other options available to VA: replacing the Charleston facility at its present location, replacing the Charleston facility on land presently occupied by the Naval Hospital in Charleston, or renovating the Charleston facility. The workgroup concluded that it would be more cost effective to renovate the current Charleston facility than to replace it with a new facility. This conclusion was based, in part, on the cost estimates for constructing a new medical center. In April 2003, the Secretary of VA sent a counterproposal to the President of MUSC, which indicated that VA preferred to remain in its current facility. The Secretary indicated, however, that if VA agreed to the joint venture, it would rather place the new facility in phase III—which is north of phase I—to provide better street access for veterans. (See fig. 3 for MUSC's proposal and VA's counterproposal.) In addition, the Secretary indicated that MUSC would need to provide a financial incentive for VA to participate in the joint venture. Specifically, MUSC would need to make up the difference between the estimated life-cycle costs of renovating the Charleston facility and building a new medical center—which VA estimated to be about $85 million—through negotiations or other means.

Figure 3: MUSC's Proposal and VA's Counterproposal




Source: VA

Note: The circle highlights some of VA's existing property.

The MUSC President responded to VA's counterproposal in an April 2003 letter to the Secretary of VA. In the letter, the MUSC President stated that MUSC was proceeding with phase I of the project and that the joint venture concept could be pursued during later phases of construction. The letter did not specifically address VA's proposal to locate the new facility in phase III, nor the suggestion that MUSC would need to provide some type of financial incentive for VA to participate in the joint venture. To move forward with phase I, the MUSC President stated that MUSC would

like to focus on executing an enhanced use lease (EUL) for Doughty Street.[10] Although MUSC owns most of the property that will be used for phases I through III, Doughty Street is owned by VA and serves as an access road to the Charleston facility and parking lots. The planned facility for phase I would encompass Doughty Street.[11] (See fig. 4.) Therefore, MUSC could not proceed with phase I—as originally planned—until MUSC secured the rights to Doughty Street. To help its medical affiliate move forward with construction, VA executed a EUL agreement with MUSC in May 2004 for use of the street.[12] According to the terms of the EUL, MUSC will pay VA $342,000 for initial use of the street and $171,000 for each of the following eight years.

[10]EUL authority allows VA to lease real property under the Secretary's jurisdiction or control to a private or public entity for a term of up to 75 years. EULs must result in a beneficial redevelopment/reuse of the affected VA property by the lessee that will include space for a VA mission-related activity and/or will provide consideration that can be applied to improve health care and services for veterans and their families in the community where the site is located.

[11]To provide access to the current VA facility, a new street—the Ralph H. Johnson Drive—will be constructed around MUSC's new facility.

[12]The Secretary of VA and the Medical University Hospital Authority (MUHA), an affiliate of MUSC, entered into a 75-year EUL agreement in May 2004 for MUHA use of VA property—a one-block segment of Doughty Street.

Figure 4: Construction of Phase One of MUSC's Project

Source: GAO.

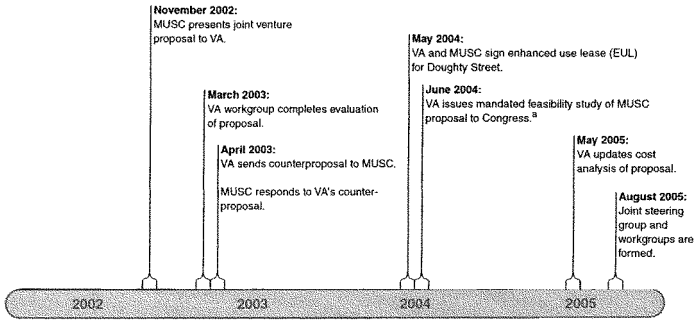
Note: The photograph shows the initial construction for phase I of MUSC's project. Doughty Street will be encompassed by MUSC's new facility.

Although both entities successfully collaborated in executing the enhanced use lease for Doughty Street, limited collaboration and communication generally characterize the negotiations between MUSC and VA over the joint venture proposal. In particular, before this summer, VA and MUSC had not exchanged critical information that would help

facilitate negotiations. For instance, MUSC did not clearly articulate to VA how replacing the Charleston facility, rather than renovating the facility, would improve the quality of health care services for veterans or benefit VA. MUSC officials had generally stated that sharing services and equipment would create efficiencies and avoid duplication, which would lead to cost savings. However, MUSC had not provided any analyses to support such claims. Similarly, as required by law, VA studied the feasibility of coordinating its health care services with MUSC, pending construction of MUSC's new medical center.[13] This study was completed in June 2004. However, VA officials did not include MUSC officials in the development of the study, nor did they share a copy of the completed study with MUSC. VA also updated its cost analysis of the potential joint venture this spring, but again, VA did not share the results with MUSC. Because MUSC was not included in the development of these analyses, there was no agreement between VA and MUSC on key input for the analyses, such as the specific price MUSC would charge VA for, or the nature of, the medical services that would be provided. As a result of the limited collaboration and communication, negotiations stalled—prior to August 2005, the last formal correspondence between VA and MUSC leadership on the joint venture was in April 2003. (See fig. 5 for a time line of key events in the negotiations between VA and MUSC.)

[13]The Veterans Health Care, Capital Asset, and Business Improvement Act of 2003, Pub. L. No. 108-170, § 232, 117 Stat 2042, 2052-2053 (2003).

**Figure 5: Time Line of Key Events in the Negotiations between VA and MUSC**




Source: GAO

[a]As required by P.L. 108-170 (2003).

## Recent Events Have Spurred Discussion and Collaboration Between VA and MUSC

On August 1, 2005, a congressional delegation visited Charleston to meet with VA and MUSC officials to discuss the joint venture proposal. After this visit, VA and MUSC agreed to establish workgroups to examine key issues associated with the joint venture proposal. Specifically, VA and MUSC established the Collaborative Opportunities Steering Group (steering group). The steering group is composed of five members from VA, five members from MUSC, and a representative from the Department of Defense (DOD), which is also a stakeholder in the local health care market.[14] The steering group chartered four workgroups, and according to VA:

- The **governance** workgroup will examine ways of establishing organizational authority within a joint venture between VA and MUSC, including shared medical services.
- The **clinical service integration** workgroup will identify medical services provided by VA and MUSC and opportunities to integrate or share

[14]The Department of Defense currently provides medical services to a number of its beneficiaries through the Naval Hospital in Charleston.

these services.

- The **legal** workgroup will review federal and state authorities (or identify the lack thereof) and legal issues relating to a joint venture with shared medical services.

- The **finance** workgroup will provide cost estimates and analyses relating to a joint venture with shared medical services.

The workgroups will help VA and MUSC determine if the joint venture proposal is mutually beneficial.[15] The workgroups are scheduled to provide weekly reports to the steering group and a final report to the steering group by October 28, 2005. The steering group is scheduled to submit a final report by November 30, 2005, to the Deputy Under Secretary for Health for Operations and Management and to the President of MUSC.

## Joint Venture Proposal Raises a Variety of Issues

The possibility of participating in the joint venture raises a number of issues for VA to consider. The proposed joint venture presents a unique opportunity for VA to reevaluate how it provides health care services to veterans in Charleston. Our ongoing work, as well as our previous work on VA's capital realignment efforts, cost-benefit analysis, organizational transformation, and performance management, however, suggests many issues to consider before making a decision about a joint venture, including governance, legal, and stakeholder issues. Some of these issues will be directly addressed by the workgroups, while others, such as the concerns of stakeholders, will not. In addition, some issues can be addressed through collaboration between VA and MUSC, while others may require VA to seek legislative remedies. Among the issues to explore are the following:

- **Comparing appropriate options and assessing the costs and benefits of all options:** According to Office of Management and Budget (OMB) guidelines on evaluating capital assets, a comparison of options, or alternatives, including the status quo, is critical for ensuring that the best alternative is selected.[16] In its guidance, OMB encourages decision makers

[15]VA's Under Secretary for Health directed the workgroups to also examine the potential for sharing services with DOD.

[16]Office of Management and Budget, Capital Programming Guide, Version 1.0 (Washington, D.C.: July 1997).

to consider the different ways in which various functions, most notably health care service delivery in this case, can be performed. OMB guidelines further state that comparisons of costs and benefits should facilitate selection among competing alternatives.[17] The finance workgroup is examining the potential costs for shared services within a joint facility. However, it is unclear whether the workgroup will weigh the benefits and costs of a new facility against those of other alternatives, including maintaining the existing medical center.

VA will also need to weigh the costs and benefits of investing in a joint venture in Charleston against the needs of other VA facilities in the network and across the nation. VA did not include the Charleston facility on its list of highest priority major medical facility construction requirements for fiscal years 2004 through 2010.[18] According to VA, the list of priorities, which includes 48 projects across the nation, aligns with existing CARES recommendations. Nevertheless, exploring the potential costs and benefits of a joint venture gives VA an opportunity to reexamine how it delivers health care services to the nation's veterans and uses its affiliations with medical universities now and in the future. As we have stated in previous reports, given the nation's long-term fiscal challenges and other challenges of the 21st Century, such reexaminations of federal programs are warranted.[19] Moreover, as the CARES Commission noted, the potential joint venture between VA and MUSC is a possible framework for future partnerships.

- **Developing a governance plan that outlines responsibilities and ensures accountability:** If VA and MUSC decide to enter into a joint venture for a new facility, they will need a plan for governing the facility. Any governance plan would have to maintain VA's direct authority over and accountability for the care of VA patients. In addition, if shared medical services are a component of a joint venture between MUSC and the VA, the entities will need a mechanism to ensure that the interests of

[17]OMB and GAO have identified benefit-cost analysis as a useful tool for integrating the social, environmental, economic, and other effects of investment alternatives and for helping decision makers identify the alternative with the greatest net benefits. In addition, the systematic process of benefit-cost analysis helps decision makers organize and evaluate information about, and determine trade-offs between, alternatives.

[18]Department of Veterans' Affairs, *CARES Major Construction Projects FY 2004 – 2010* (Washington, D.C.: May 2004).

[19]GAO, *21st Century Challenges: Reexamining the Base of the Federal Government*, GAO-05-325SP (Washington, D.C.: February 2005).

the patients served by both are protected today and in the future. For instance, VA may decide to purchase operating room services from MUSC.[20] If the sharing agreement was dissolved at some point in the future, it would be difficult for VA to resume the independent provision of these services. Also, if MUSC physicians were to treat VA beneficiaries, or VA physicians were to treat MUSC patients, each entity would need a clear understanding of how to report health information to its responsible organization. Therefore, a clear plan for governance would ensure that VA and MUSC could continue to serve their patients' health care needs as well as or better than before.

- **Identifying legal issues and seeking legislative remedies**: The proposed joint venture raises a number of complex legal issues depending on the type of joint venture that is envisioned. Many of the legal issues that will need to be addressed involve real estate, construction, contracting, budgeting, and employment. The following are among some of the potential issues relating to a joint venture that VA previously identified:

  - What type of interest will VA have in the facility? If MUSC is constructing the facility on MUSC property, will VA be entering into a leasehold interest in real property or a sharing agreement for space, and what are the consequences of each? If the facility is to be located on VA property, will it involve a land transfer to MUSC or will VA lease the property to MUSC under its authority to enter into a EUL agreement? What are the advantages and disadvantages of these options?

  - Because MUSC contracting officials do not have the authority to legally bind the VA, how would contracting for the services and equipment be handled?

The legal workgroup is currently identifying VA's and MUSC's legal authorities, or lack thereof, on numerous issues relating to entering into a joint venture. Should VA decide to participate in the joint venture, it may need to seek additional authority from the Congress.

[20]Such purchases of health care or other services from MUSC would involve contracts that VA would have to manage with oversight mechanisms, such as pre- and postaward audits, as it now does for current contracts with MUSC.

- **Involving stakeholders in the decisionmaking process:** Participating in a joint venture medical center, particularly if it includes significant service sharing between VA and MUSC, has significant implications for the medical center's stakeholders, including VA patients, VA employees, and the community. These stakeholders have various perspectives and expectations—some of which are common to the different groups, while others are unique. For example, union representatives and VA officials whom we spoke to indicated that VA patients and employees would likely be concerned about maintaining the quality of patient care at a new facility and access to the current facility during construction. Union representatives also said the employees would be concerned about the potential for the loss of jobs if VA participated in the joint venture and purchased additional services from MUSC. As VA and MUSC move forward in negotiations, it will be important for all stakeholders' concerns to be addressed.

- **Developing a system to measure performance and results:** If VA and MUSC decide to jointly build and operate a new facility in Charleston, it will become, as noted in the CARES Commission report, a possible framework for future partnerships between VA and other medical universities. As a result, a system for measuring whether the new joint venture facility is achieving the intended results would be useful.[21] In our previous work on managing for results, we have emphasized the importance of establishing meaningful, outcome-oriented performance goals.[22] In this case, potential goals could be operational cost savings and improved health care for veterans. If the goals are not stated in measurable terms, performance measures should be established that translate those goals into concrete, observable conditions.[23] Such measures would enable VA and other stakeholders to determine whether progress is being made toward achieving the goals. This information could not only shed light on the results of a joint venture in Charleston, but it could also enable VA to identify criteria for evaluating other possible joint ventures with its medical affiliates in the future. It would also help Congress to hold VA accountable for results.

[21]Under the Government Performance and Results Act of 1993 (GPRA), VA is required to develop performance goals for its major programs and activities and measures to gauge performance. VA's experience with GPRA could help them develop appropriate goals and measures for the joint venture.

[22]GAO, *Results Oriented Government: Using GPRA to Address 21st Century Challenges*, GAO-03-1166T (Washington, D.C.: September 2003).

[23]GAO, *The Results Act: An Evaluator's Guide to Assessing Agency Annual Performance Plans*, GAO/GGD-10.1.20 (Washington, D.C.: April 1998).

## Concluding Observations

In conclusion, Mr. Chairman, we have stated over the past few years that federal agencies, including VA, need to reexamine the way they do business in order to meet the challenges of the 21st century. To address future health care needs of veterans, VA's challenge is to explore alternative ways to fulfill its mission of providing veterans with quality health care. The prospect of establishing a joint venture medical center with MUSC presents a good opportunity for VA to study the feasibility of one method—expanding its relationships with university medical school affiliates to include the sharing of medical services in an integrated facility. This is just one of several ways VA could provide care to veterans. Evaluating this option would involve VA officials, working in close collaboration with MUSC officials, weighing the benefits and costs as well as the risks involved in a joint venture against those of other alternatives, including maintaining the current medical center. Determining whether a new facility for Charleston is justified in comparison with the needs of other facilities in the VA system is also important. Until these difficult, but critical, issues are addressed, a fully-informed final decision on the joint venture proposal cannot be made.

Mr. Chairman, this concludes my prepared statement. I will be happy to respond to any questions you or other Members of the Subcommittee may have.

## Contact and Acknowledgments

For further information, please contact Mark Goldstein at (202) 512-2834. Individuals making key contributions to this testimony include Nikki Clowers, Daniel Hoy, Jennifer Kim, Edward Laughlin, Donna Leiss, James Musselwhite Jr., Terry Richardson, Susan Michal-Smith, and Michael Tropauer.

# Related GAO Products

*VA Health Care: Key Challenges to Aligning Capital Assets and Enhancing Veterans' Care.* GAO-05-429. Washington, D.C.: August 5, 2005.

*Federal Real Property: Further Actions Needed to Address Long-standing and Complex Problems.* GAO-05-848T. Washington, D.C.: June 22, 2005.

*VA Health Care: Important Steps Taken to Enhance Veterans' Care by Aligning Inpatient Services with Projected Needs.* GAO-05-160. Washington, D.C.: March 2, 2005.

*High-Risk Series: An Update.* GAO-05-207. Washington, D.C.: January 2005.

*VA Health Care: Access for Chattanooga-Area Veterans Needs Improvements.* GAO-04-162. Washington, D.C.: January 30, 2004.

*Budget Issues: Agency Implementation of Capital Planning Principles Is Mixed.* GAO-04-138. Washington, D.C.: January 16, 2004.

*Federal Real Property: Vacant and Underutilized Properties at GSA, VA, and USPS.* GAO-03-747. Washington, D.C.: August 19, 2003.

*VA Health Care: Framework for Analyzing Capital Asset Realignment for Enhanced Services Decisions.* GAO-03-1103R. Washington, D.C.: August 18, 2003.

*Department of Veterans Affairs: Key Management Challenges in Health and Disability Programs.* GAO-03-756T. Washington, D.C.: May 8, 2003.

*VA Health Care: Improved Planning Needed for Management of Excess Real Property.* GAO-03-326. Washington, D.C.: January 29, 2003.

*Major Management Challenges and Program Risks: Department of Veterans Affairs.* GAO-03-110. Washington, D.C.: January 2003.

*High-Risk Series: Federal Real Property.* GAO-03-122. Washington, D.C.: January 2003.

*VA Health Care: VA Is Struggling to Address Asset Realignment Challenges.* GAO/T-HEHS-00-88. Washington, D.C.: April 5, 2000.

*VA Health Care: Improvements Needed in Capital Asset Planning and Budgeting.* GAO/HEHS-99-145. Washington, D.C.: August 13, 1999.

*VA Health Care: Challenges Facing VA in Developing an Asset Realignment Process.* GAO/T-HEHS-99-173. Washington, D.C.: July 22, 1999.

*VA Health Care: Capital Asset Planning and Budgeting Need Improvement.* GAO/T-HEHS-99-83. Washington, D.C.: March 10, 1999.

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Washington, D.C. 20548

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**Statement of**
**The Honorable Tim S. McClain**
**General Counsel and Chief Management Officer**
**U.S. Department of Veterans Affairs**

**At a Field Hearing in Charleston, SC**
**Before The**
**Subcommittee on Health**
**Committee on Veterans' Affairs**
**United States House of Representatives**

**September 26, 2005**
***

Chairman Buyer, Chairman Brown, Chairman Miller and members of the Subcommittee:

Thank you for providing the Department of Veterans Affairs this opportunity to discuss our valued partnership with the Medical University of South Carolina. Accompanying me this morning are Mr. William A. Mountcastle, Director of the Ralph H. Johnson VA Medical Center and Mr. Michael Moreland, Director of the VA Pittsburgh Healthcare System.

The Department of Veterans Affairs is fully committed to providing veterans with the best health care available. The results of that commitment have been reported in several major medical journals and in the media as VA is proudly setting the standard of care in many areas. Copies of many of the articles were provided to the members of this committee following the full committee hearing on September 14, 2005. VA has also received national recognition, and the recognition of this Committee, for our efforts during the aftermath of Hurricane Katrina in the Gulf Coast region.

The Ralph H. Johnson VA Medical Center (VAMC) in Charleston serves over 37,000 veterans from the coastal South Carolina and Georgia area. The outstanding quality of care delivered at the Charleston VAMC is evident through their continued success on VA's national clinical performance measures along with the assessment by the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) that their delivery of key services exceeds that of most JCAHO approved health care providers.

Like many Veterans Affairs medical centers, the Charleston VAMC has a very close relationship with its affiliate. Successful collaborative sharing between the VA and the Medical University of South Carolina (MUSC) has been going on for many years. This collaborative relationship recently included the signing of an Enhanced Use Lease which allowed MUSC to begin construction on their Phase I facility on campus. As the planning for MUSC's other major construction projects unfolds, there may be additional opportunities to partner in the care of the South Carolina's veterans as well as some servicemembers and beneficiaries of the Department of Defense. The Charleston VAMC will purchase over $17 million in specialty services from MUSC in 2005, including $4.5 million for radiation therapy, $3.6 million for resident staff, over $687,000 for cardiothoracic surgery services and over $4 million of various other services. Also, this beautiful shared research building we are in for this hearing is a prime example of the collaboration between MUSC and VA.

In late August 2005, the Veterans Health Administration charged a national group to assist in this continued review. Mr. Michael Moreland, Director of the VA Pittsburgh Healthcare System and a member of VHA's national finance council, was asked to co-chair a Collaborative Opportunities Steering Group (COSG) with Raymond Greenberg, MD, PhD, President of MUSC.

The COSG group has begun its work and is developing opportunities for future collaboration in the short and long term. As mentioned above, there is significant collaboration and sharing currently between MUSC and VAMC Charleston.

The group is reviewing opportunities for enhanced collaboration that can occur in the short term, perhaps for inclusion in the MUSC's current construction, and in the longer term to evaluate the cost and benefit of constructing a new VA medical center. All options must be explored before taxpayer dollars are committed to any major construction project. Should the steering group develop proposals to embark on a joint construction project at Charleston, it will also have to be in concert with VA's CARES decisions and the Department's long-range construction goals as stated in the VA 5-Year Capital Plan. The potentially heavy financial impact of Hurricane Katrina on VA facilities and available funding must also be taken into account.

While VA is optimistic about the potential for a federal-state model, we are also realistic enough to know that we must keep an open mind and explore all options for our veterans before committing scarce taxpayer dollars. Secretary Nicholson's ultimate decision point will be whether a proposal benefits veterans and is fiscally responsible. We do not intend to pre-judge the results of the feasibility studies. Any recommendation to embark on a joint construction project at Charleston must be in concert with the CARES decisions and the Department's long-range construction goals. In other words, it must make good sense fiscally and from a business aspect. VA owes that to all veterans, including the many veterans in South Carolina. Also, we feel that the Department of Defense (DoD) should be considered in any plans for a shared facility. The President's Management Agenda has placed a strong emphasis on VA-DoD sharing and our staff has been directed to identify every opportunity for joint healthcare operations with the various components of DoD.

Whatever options the group puts forward, we are confident that by continuing to work together to assure a mutually beneficial plan, VA can enhance care to veterans while building on its collaborative relationship with the Medical University of South Carolina.

Mr. Chairman, this concludes my statement. My colleagues and I will be happy to answer any questions that you or other members of the Subcommittee might have.

**Testimony to the U.S. House of Representatives**
**Committee on Veterans' Affairs**
**Subcommittee on Health**

**Presented by:**
**Raymond S. Greenberg, MD, PhD**
**President, Medical University of South Carolina**

**September 26, 2005**

Mr. Chairman and members of the Committee, thank you for inviting me to testify today. It is a privilege to share my thoughts with you, and also to host you on the campus of the Medical University of South Carolina (MUSC).

First and foremost, I am here to tell you how much the Medical University values its relationship with veterans and with the Veterans' Administration (VA). South Carolinians have served our nation in the armed services with pride and with distinction. Many have suffered serious health consequences of their service and it is a privilege for us to be able to help care for these veterans as a partner with the VA.

Our relationship with the VA is deep and long-standing. We work with our colleagues at the VA in every aspect of our mission. In clinical care, virtually all of the attending physicians at the Charleston (Ralph H. Johnson) VA Medical Center (VAMC) are MUSC faculty members. In the educational arena, all of the physicians-in-training at the Charleston VAMC are in MUSC residencies. With respect to research, many of the most productive scientists at MUSC are investigators in the VA system. In fact, the facility in which we are meeting today is a visible symbol of our collaboration – the Strom Thurmond Research Building is owned by the Medical University, but half of the laboratory space is leased to the VA to conduct its scientific work. This joint research building, now in operation for more than eight years, is one of only a handful of such shared facilities in the country. It works and it works well. We believe

the same type of success can be achieved by coordinating facilities in the clinical arena.

Before proceeding further, let me emphasize here that the first priority in considering any linkage of MUSC and VA hospitals is to better meet the health care needs of veterans. **It is our position that any deal that does not improve health care for veterans is not a good deal for anybody.**

In that light, let me advance the case for closer integration of hospital facilities. First, both the Ralph H. Johnson VAMC and the Medical University have aging hospitals. Both have been maintained admirably, but the fact remains that they were designed 40 to 50 years ago, and as a result, cannot accommodate the size and complexity of contemporary medical equipment and technology. Therefore, they are not the best environment for delivering state-of-the-art care. Recognizing those limitations, the Medical University has begun the stepwise process of replacing its hospital, the first phase of which is under construction across the street and will be completed by early 2007. The immediate adjacency of this site to the Ralph H. Johnson VAMC makes it feasible to build future facilities in a cooperative way.

Second, the devastation that Hurricane Katrina wrought on the Gulf Coast VAMCs serves as a warning about what could happen in Charleston. The Ralph H. Johnson VAMC is built on low-lying land adjacent to a tidal river in a hurricane prone coastal area. It also sits in a city with a history of destructive earthquakes. This facility was designed prior to current standards for wind, flood and earthquake resistance. Let us not allow the disaster of Hurricane Katrina to be revisited in this vulnerable setting.

Third, building integrated facilities would allow sharing of infrastructure, such as expensive operating rooms and imaging equipment. By avoiding duplicating this infrastructure, money could be saved on both sides and redirected back into providing more services to patients. Everybody in this room is well aware of the spiraling costs of health care and anything

that can be done to reduce costs in the future is something that warrants our support and encouragement.

Fourth, we believe that the quality of care will be improved by integrating facilities. For example, in certain specialty areas for which the Medical University is nationally recognized, such as the treatment of digestive disorders, the Ralph H. Johnson VAMC could be designated as a VA Center of Excellence, so that veterans would not have to travel from their homes in South Carolina to remote specialty centers, such as Atlanta. From the VISN level, a center of excellence in Charleston would also allow consolidation of some services here, avoiding duplication elsewhere.

**Let me state emphatically here, that we are not proposing that the MUSC would "take over" the operation of the VA.** Quite to the contrary, we want to preserve all of the current advantages of a dedicated VA hospital, while saving the federal government money and increasing service capabilities. **Any coordination of facilities would be guided by principles to protect the interests of veterans and those who serve them.** First, there would be a dedicated veterans' bed tower, so that veterans would not be housed interspersed in with other patients. Second, the VAMC identity would be displayed prominently on its facilities. Third, veterans will be guaranteed to have equal or preferred access to any and all shared facilities. Fourth, the dedicated employees of the VAMC would be given every consideration in any integration of staffing.

There is no existing model for what we are proposing, so we cannot simply copy what has been done elsewhere. The hard work of exploring this opportunity has begun with representatives of the VA and the Medical University meeting regularly for the past six weeks. These meetings have been highly productive and I commend the spirit of cooperation that has been demonstrated on both sides. Four working groups have been organized to deal respectively with issues concerning: (1) clinical integration, (2) governance, (3) finance, and (4) legal matters. An oversight group has been setting the general direction and coordinating the work of the

four groups. An interim report of our progress has just been completed, and with your permission Mr. Chairman, I would like to have that report admitted into the official record of this hearing.

Again, thank you for allowing me the opportunity to address you this morning.

**Statement Disclosing Federal Grant or Contract**
**(Relevant to the Subject Matter of Testimony)**
**Received During the Current Fiscal Year**
**or Previous Two Fiscal Years**
**by the Witness or the Organization Represented by the Witness**

Raymond S. Greenberg, MD, PhD: None

Medical University of South Carolina
The following list represents services Charleston VAMC currently purchases from MUSC on an annual basis:

| Service | Annual Amount |
|---|---|
| Anesthesiology | $321,148 |
| Cardiologist | $232,000 |
| Cardiothoracic Surgery | $687,308 |
| Gastroenterology | $350,000 |
| Infectious Disease | $104,000 |
| Internal Medicine | $203,452 |
| Neurosurgery | $325,000 |
| Orthopedic Surgery | $130,000 |
| Perfusionist | $110,000 |
| Pulmonary Care | $326,000 |
| Vascular Surgery | $240,000 |
| Radiation Therapy | $4,500,000 |
| Pet Scan | $500,000 |
| Dermatologic Surgery | $500,000 |
| All other fee basis | $4,000,000 |
| Resident Staff | $3,600,000 |
| Research Lease | $1,200,000 |
| Annual TOTAL | $17,328,908 |

# Appendix A:

# Strom Thurmond Biomedical Research Center/ Gazes Cardiac Research Institute

## Strom Thurmond Biomedical Research Center/ Gazes Cardiac Research Institute

- Houses research efforts of both MUSC and the VAMC in cardiology, nephrology, infectious diseases, hematology, and endocrinology
- Constructed at a cost of $31 million
- Dedicated in 1996
- 180,000 square feet of space
- VA leases 47,000 square feet from MUSC, at a cost of $27 per square foot
- 20-year lease: January 1997 through December 2017
- Separate administrative space and offices
- Separate but coordinated laboratory animal care programs

# Appendix B:

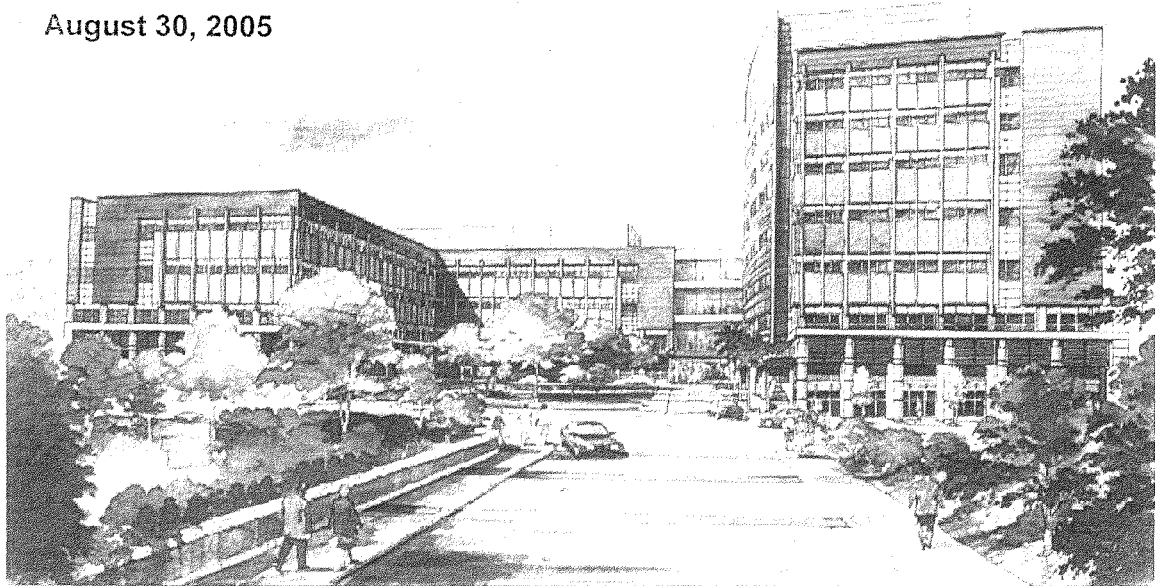
# Hospital Project, Phase I

# Hospital Replacement Project

## Project Overview

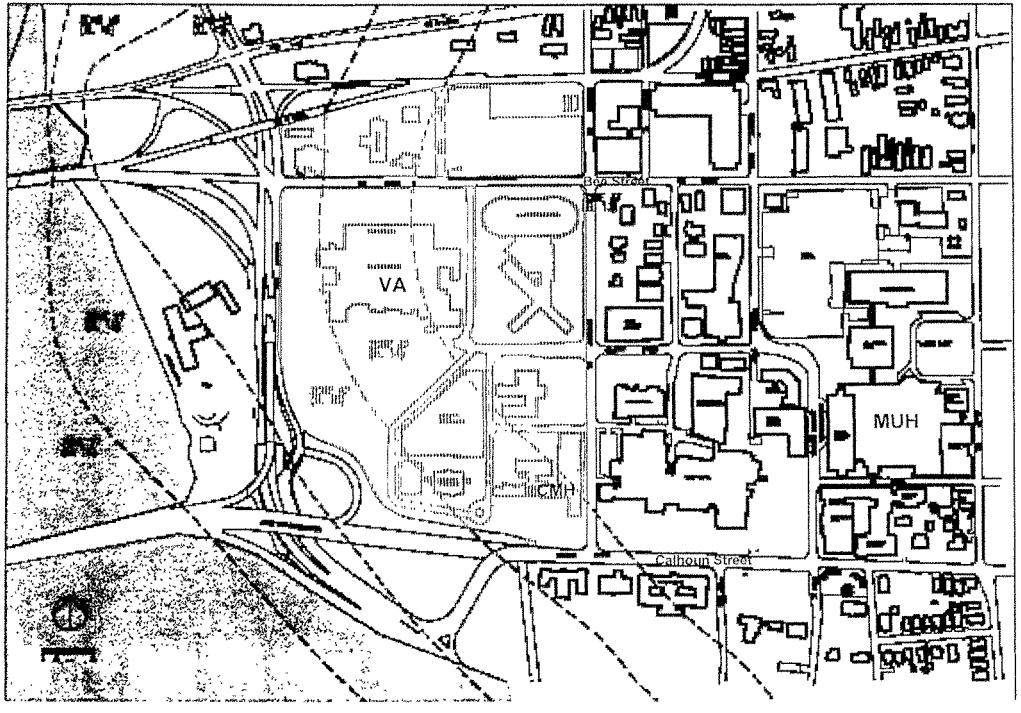
MUSC
MEDICAL UNIVERSITY
OF SOUTH CAROLINA

August 30, 2005



*Front Entrance on Courtenay Drive*

# Existing Campus - Development of a Clinical Zone




MUSC

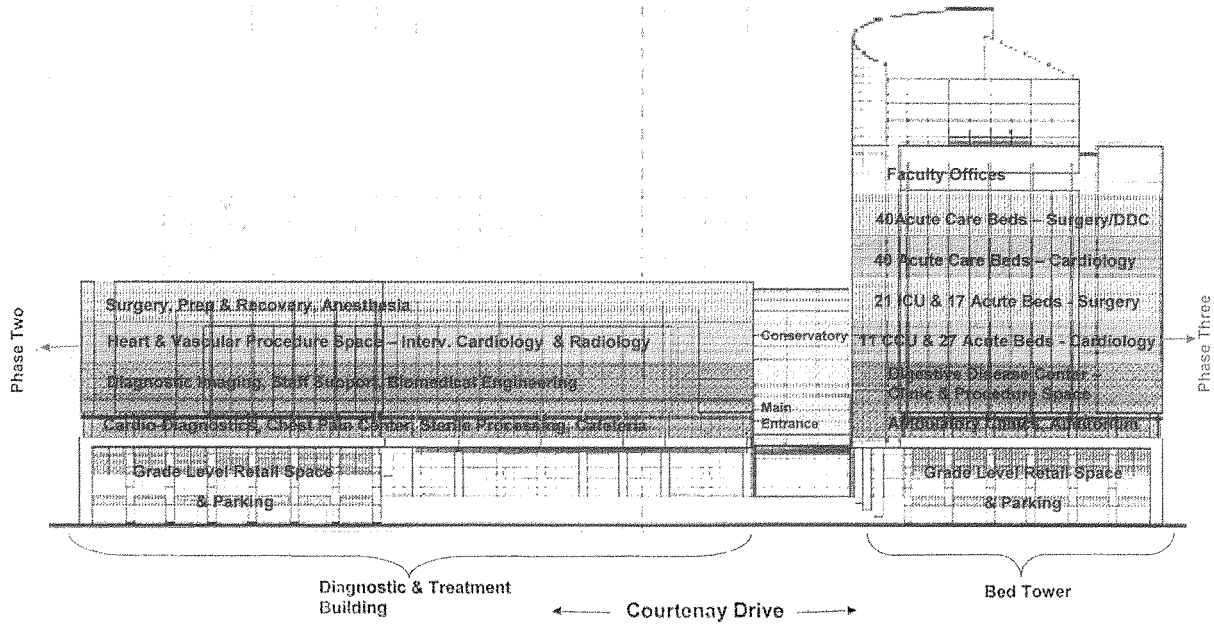
# Phase I Components

Hospital

641,000 GSF

- 156 Beds for Cardiovascular and Digestive Disease Services (includes 32 ICU beds)
- 9 Operating Rooms including one equipped with fixed equipment for vascular surgery
- 3 Electrophysiology Labs, 4 Interventional/Diagnostic Cath Labs, 2 Interventional Radiology Labs (plus a third IR lab equipped with CT noted below)
- 9 Endoscopy Suites (including high tech ERCP & EUS suites) and 2 Motility Rooms
- Outpatient Clinics (to accommodate approx. 120,000 visits) and Associated Faculty Offices
- Specialized Chest Pain Center (includes observation beds)
- Imaging Capacity to include 2 diagnostic CTs, 1 interventional CT, 1 diagnostic MRI, 3 nuclear cameras, 3 RF rooms, and space for new modality to serve chest pain center and outpatient cardio-diagnostics

# East Elevation – Stacking Diagram




MUSC

# Phase I Components

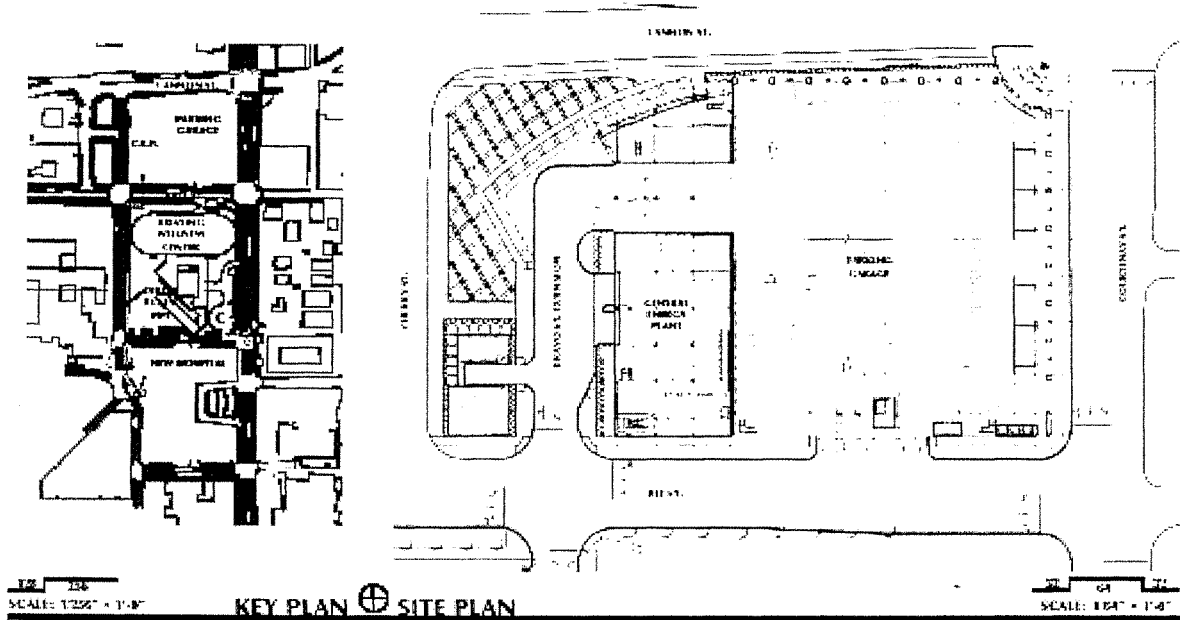
C.E.P.

- **Boiler Plant**
- **Chillers/ Cooling Towers**
- **Power Distribution Center**
- **Approximately 52,000 GSF**



MUSC

# Central Energy Plant – Site Plan




MUSC

# Appendix C: Memorandum of Record

14 - 16

**Memorandum of Record**

Meetings were convened by Congressmen Steve Buyer and Henry Brown on Monday, August 1, 2005 in Charleston, South Carolina. These meetings were focused on a recommendation of the Capital Asset Realignment for Enhanced Services (CARES) Commission that "VA will continue to consider options for sharing opportunities with the Medical University of South Carolina" (MUSC). Attending these meetings were Congressmen Buyer and Brown, several of their senior staff members, as well as leaders of MUSC administration and clinical staff, the VA Central Office, VISN 7 and the Charleston VAMC.

The group acknowledged the strong positive working history between the VAMC and MUSC. Both groups affirmed their commitment to the highest quality health care of veterans that they had mutually been dedicated to since 1965. Also, the geographic proximity of the MUSC replacement hospital to the VAMC property makes sharing a logical subject for continued study, along with study of the feasibility of future integrated facilities. By sharing core services, duplication of facilities and equipment can be avoided, thereby lowering capital construction costs to both governmental (Federal and State) entities. In addition, operational efficiencies could be possible by potentially sharing clinical services and facilities, while assuring access to the highest quality of patient care to veterans. The group, therefore, accepted the premise that enhanced sharing is a worthy goal for both entities.

The group also acknowledged that there are many issues that must be addressed in achieving this goal. Initial discussion revealed four categories of issues that would be most pressing to consider:

1. Governance
2. Finance
3. Clinical service integration
4. Legal

It was agreed that working groups will be formed to identify the principal issues under each of these broad categories and ways to address these issues successfully. Co-chairs from the VA organization and from MUSC were nominated for each of these groups. A steering committee comprised of these working group chairs and other leaders of the entities will be formed to assure good communication and coordination of the activities of the working groups.

It was also agreed that there would be value to jointly retaining outside facilitators experienced in hospital planning and construction to help the working groups complete their respective tasks as quickly as possible. Mechanisms and resources for retaining these facilitators will be explored promptly by the VA and MUSC. A target for discussion of preliminary findings of the work groups will be a Field Hearing potentially sponsored jointly by the US House and Senate and tentatively scheduled for September 26, 2005.

This summary was jointly prepared and endorsed by the undersigned on August 18, 2005.

Raymond S. Greenberg, MD, PhD
President, MUSC

Tim S. McClain
General Counsel
U.S. Department of Veterans Affairs

## Appendix D: Working Group Membership List

**Collaborative Opportunities Steering Group**

| *VA* | *MUSC* |
|---|---|
| VHA Co-Leader- Michael Moreland, Director, VA Pittsburgh Healthcare System | Raymond Greenberg, President, MUSC, Co-Leader |
| Brian Heckert, Director, Columbia Veterans Affairs Medical Center | Stuart Smith, MUSC Hospital CEO |
| Walt Hall, VACO Group 3 Lead Counsel | John (Jack) Feussner, MUSC Chair, Department of Medicine |
| Mike Finegan, Director, Buffalo VAMC | Lisa Montgomery, VP for Finance and Administration |
| Carter E. Mecher, Chief Medical Officer, VISN 7 | Joseph (Jerry) Reves, VP for Medical Affairs and Dean College of Medicine, MUSC |
| RADM T K Burkhard, BUMED East, DoD<br>CAPT S Widhalm, DoD | Marion Woodbury, Special Assistant to the President |
| **Staff Support** – Carla Sivek, Rick Mahon | Chris Malanuk, Planner |

**Group 1 - Governance**

| *VA* | *MUSC* |
|---|---|
| Brian Heckert, Director, Columbia VAMC, Co-Leader | Stuart Smith, MUSC Hospital CEO, Co-Leader |
| William Mountcastle, Director, Charleston VAMC | Marion Woodbury, Special Assistant to the President |
| Richard R. Robinson (OGC), General Counsel, VACO | Betts C. Ellis, Hospital Administration |
| Joseph Pomorski, HR Consultant, VHA Management Support Office | John Heffner, Executive Medical Director, Medical University Hospital Authority; Professor |
| Judith Zboyovski, Quality Management Officer, VISN 4 | Reece H. Smith, Compliance Officer |
| Gary M. Baker, Director, Health Eligibility Center | |
| **Staff Support** | **Staff Support** |
| Rick Mahon | Teresa Rogers |

**Group 2 - Legal**

| *VA* | *MUSC* |
|---|---|
| Walt Hall, VA General Counsel, Group 3-Co-Leader | John (Jack) Feussner, MUSC Chair, Department of Medicine, Co-Leader |
| Phillipa Anderson, VA General Counsel, Group 2 | Annette Drachman, Director, Legal Affairs, MUSC Medical Center |
| John Pressly, Asst. Regional Counsel | Joseph C. Good, University General Counsel |
| Ed Bradley, Portfolio Manager, Office of Asset Enterprise Mgmt (OAEM) | Andrea Barrett, Paralegal |
| Michael J. Cunningham, Contracting Officer - VISN 12 | Karen Rae, Director of Managed Care |
| Jodie Babb, Louisville VAMC VA/DoD Sharing Program | Lisa Kindy, Legal Counsel College of Medicine |
| **Staff Support** | **Staff Support** |
| Sharon Snellgrove, Muriel Phillips | Mary Hudson |

**Group 3 – Finance**

| *VA* | *MUSC* |
|---|---|
| Michael Finegan, Director, Syracuse VAMC, Co-Leader | Lisa P. Montgomery, VP for Finance and Administration, Co-Leader |
| Marcia Balonis - CFO, Charleston VAMC | John L. Cooper, Director, Finance |
| Victor V. C. Cruz, Asheville – Medical Care Collection Fund (MCCF) Director, VISN 6 | Karen Rae, Director of Managed Care |
| Lynn Ryan, VISN 16 CFO | Bruce A. Quinlan, Director, University Medical Associates |
| David Bach, VISN 18 CFO | Bo Faulkner |
| **Staff Support** | **Staff Support** |
| Josh Malecki | Celeste Jordan, Janice Pappas |

**Group 4- Targets for Shared Clinical Services**

| *VA* | *MUSC* |
|---|---|
| Dr. Carter Mecher - CMO VISN 7, Co-Leader | Dr. Joseph (Jerry) Reves, VP Medical Affairs and Dean College of Medicine, Co-Leader |
| Cathy Rick, Chief Nursing Officer | Dr. John Heffner, Executive Medical Director, MUHA |
| Contracting: Augustin Davila, VISN 6 CLO | Dr. Bruce M. Elliott, Senior Assoc. Dean for Clinical Affairs, MUSC |
| Linda Fischetti, Management Analyst, OIT-HES / HIS | Ed Cousineau, Associate Dean, MUSC |
| IT: Cliff Freeman, Director VA / VOD Interagency Prog., OIT | Marilyn Schaffner, Administrator, Clinical Services, MUH |
| Dr. Robert Jesse- PCS- National Director for Cardiology | Dr. John Waller, Director, Medical Informatics, MUSC |
| Dr. Ralph DePalma.-PCS-National Director Surgery | Hal Currey, Hospital Project Advisor, MUH |
| **Staff Support** | **Staff Support** |
| Jackie L. McGee | Beverly Carson, Staff |

**Ralph H. Johnson Veterans Affairs Medical Center**
**Charleston, South Carolina**
**and**
**The Medical University of South Carolina**

# Collaborative Opportunities Steering Group

## Progress Report

**September 22, 2005**

**Ralph H. Johnson Veterans Affairs Medical Center (Charleston VAMC) and Medical University of South Carolina (MUSC)**

**Joint Opportunities Review Status**

To study options for enhanced sharing between the Charleston VAMC and the MUSC, as well as potential collaboration with the Department of Defense, a joint Collaborative Opportunities Steering Group (COSG) was formed in August 2005. This group, with the input of four workgroups: Governance, Finance, Legal, and Shared Clinical Services, has compiled the following information for further study. Membership of the group led by Mr. Michael Moreland and Dr. Ray Greenberg and the workgroup membership is shown in the attachment at the end of this report. The group has weekly telephone discussions and has met face-to-face twice in Charleston, on August 30 and September 19, 2005.

Discussion with the Department of Defense occurred by telephone and during a face-to-face meeting on September 20, 2005.

**Current VA/MUSC Sharing**
The following list represents services Charleston VAMC currently purchases from MUSC on an annual basis:

| Service | Annual Amount |
|---|---|
| Anesthesiology | $321,148 |
| Cardiologist | $232,000 |
| Cardiothoracic Surgery | $687,308 |
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| Radiation Therapy | $4,500,000 |
| Pet Scan | $500,000 |
| Dermatologic Surgery | $500,000 |
| All other fee basis | $4,000,000 |
| Resident Staff | $3,600,000 |
| Research Lease | $1,200,000 |
| Annual TOTAL | $17,328,908 |

**Current Charleston VAMC/Department of Defense (DoD) Sharing**
Charleston VAMC has a small community based outpatient clinic (CBOC) within Beaufort South Carolina Naval Hospital. VAMC leases space and Navy performs Lab and radiology services for VA patients. VAMC has also hired a phlebotomist

who works in the Navy lab and assists with blood draws for both VA and DoD patients. Discussions are underway to identify additional opportunities to enhance the existing sharing relationship.

**Future opportunities For Charleston VAMC to collaborate with DoD**
Charleston VAMC is a partner in a joint venture with the Charleston Naval Hospital on the construction of a new Navy Ambulatory Care Center to be located on the grounds of the Naval Weapons Station, Goose Creek, SC. VA is contributing construction funds to the project and will operate a CBOC within the new facility. There is ongoing discussion between Charleston VAMC and Charleston Naval Hospital staff on the many sharing opportunities this relationship will present.

**Opportunities for Enhanced Sharing in Phase I of MUSC Construction**
The group is performing a cost analysis of equipment that could be shared in the first phase of MUSC construction. For example, VA is seeking quotes on the cost of CT, MRI and/or PET for possible installation in the new MUSC facility in return for free or reduced-cost tests for veteran patients of Charleston VAMC. If mutually agreeable, these items would be purchased and owned by VA, installed in MUSC space, operated by MUSC, and VA would receive discounted services in a sharing agreement in consideration for the purchase of the equipment.

**Opportunities for Joint Construction or Sharing in Future Construction**
The COSG reached agreement on a set of criteria that a joint venture scenario must demonstrate to merit further consideration:

- Enhance quality and service
- Improve access
- Financially viable
- Optimal legal authorities
- Enhance efficient infrastructure sharing
- Maximize land utilization/develop footprint
- Collaborative governance structure
- Maintain unique VA identity
- Regional (VISN) center of excellence
- Enhance DoD services
- Serendipitous win-wins
- Can become a national model for collaborations

Four construction planning models are being studied for feasibility and cost effectiveness. At this point, all four models include the construction of a VA parking structure to maximize land use while enhancing veteran access. The planning models also include some reduction of administrative space to facilitate sharing or contracting of some services. Preliminary details of which services would be provided by VA and MUSC are being reviewed.

*Model A* is studying the feasibility of constructing a new VA facility as the next phase of local construction. In addition to replacing all clinical services in the existing VA facility, inpatient capacity constructed would accommodate additional beds needed by MUSC. The beds in excess to VA need would then be leased to MUSC under a long-term agreement.

*Model B* proposes the construction of a replacement VA facility with construction of somewhat less inpatient capacity for lease to MUSC.

Under *Model C*, a replacement VAMC would be constructed with only the bed capacity projected to be needed for VA use.

*Model D* would develop opportunities for sharing of clinical services and equipment within the existing VA facility and separate MUSC facilities.

**Ongoing Study**

The four workgroups are responsible for detailed analysis of these options and development of others as appropriate. Their work, and the review of the steering group, will result in a better understanding of the feasibility of sharing options for VA, MUSC and the Department of Defense to collaborate in the delivery of health care in Charleston for the future. MUSC and VA continue to work cooperatively on the outlined review and it is anticipated that their positive, collaborative relationship will continue regardless of the outcome of the above analysis.

Reports of the scope of each of those groups, the progress made in their reviews, and their planned, ongoing study follow.

**Shared Clinical Services Workgroup**
**Progress Report to the COSG**

***Focus and Scope*** The Collaborative Opportunities Steering Group (COSG) was charged to conduct a preliminary analysis to determine what, if any, mutually beneficial consolidation should occur between the Charleston VAMC and MUSC. As a subcommittee of the COSG, the Shared Clinical Services Workgroup's focus was to identify present Charleston VAMC and MUSC sharing arrangements that support the health care requirements of the Charleston VAMC and MUSC, and to identify and recommend whether additional clinical services can be shared. Consideration was to be given in terms of service, quality, access, practicality, and efficiency. This workgroup set as its mission to determine which clinical services can be shared in any future joint building of new facilities. Furthermore, the group is to estimate the approximate size and impact of the facility that will accommodate joint clinical needs. The charge for the COSG also included provisions for including the Department of Defense (DoD) in the planning for services. It was decided that the DoD involvement in the needs assessment and planning will be at the level of the COSG and not this workgroup. Vital precedents exist in the VA for shared arrangements: VHA has experience with shared facilities in three locations with DoD hospitals. In addition, precedent exists for university hospitals to utilize VHA assets in VHA facilities (operating rooms) on contract for private cases.

***Progress*** The goals of collaboration between MUSC and the VA should focus on increasing quality of services, improving access to services, lowering overall facility and operational costs, and ensuring maximal use of the land resources. To ensure maximal use of land resources and lower overall facility operational costs, collaborative opportunities could involve the VA constructing and equipping beds and services and then the VA leasing those assets back to MUSC, the VA selling those services back to MUSC, or MUSC staffing specific areas and selling those services at a discounted price back to the VA. MUSC has a single entity (University Medical Associates) for pursuing any contractual arrangements, in lieu of negotiating with individual practice groups and the hospital.

Consensus is that it is essential that the VA have a bed tower, including general medical and surgical ICU beds, which clearly is designated as a "VA Hospital."

Subgroups in Medicine, Surgery, Laboratory/Pathology and Radiology were established to identify opportunities for sharing and to develop various options of shared clinical services. All groups reported options ranging from stand alone (status quo) through full integration. Suggested scenarios discussed for each specific area included status quo (current level of contracting of clinical services), high contracting—services provided by MUSC and sold to VA, high contracting—services provided by the Charleston VAMC and sold to MUSC, hybrids—services provided as a mixture of "tiered" services (some services provided in-house by the VA and some services purchased from MUSC including the provision for after

hours coverage). Subgroups made up of 2 specialists representing the VA and MUSC (total of 4) were formed to address the 4 main service areas. Preferences of a single model have not been reported but below are summaries of services that lend themselves in the subgroups to being shared:

*Medicine*

- Cath labs and EP
- Combined endoscopy unit if there is a separate free-standing ambulatory unit
- Single ER services
- Night call for all inpatients with a single team
- Back to back or single dialysis units
- Joint sleep lab
- Joint bronchoscopy labs
- Create VA regional centers of excellence in GI endoscopy and cardiology (EP, surgery, and interventional cardiology)
- Ambulatory clinics would be separate
- Because the VA offers chronic outpatient dialysis in its facility and MUSC does not, there may still be a need for separate dialysis units. A common, shared "back-to-back" reverse osmolarity water system is highly desirable.

*Surgery*

- Duplication of expensive equipment should be avoided
- Staff coverage for emergencies and night/weekend is facilitated by a joint inpatient surgical program
- Clinical research is enhanced with combined surgery – OR's could be shared
- Combined surgery would enhance results by having larger volumes. Many, but not all, surgeons work at both institutions. Aggregating all surgical cases from both institutions more accurately reflects the combined surgical expertise than do statistics for each institution in a stand alone setting. Currently the VA refers the cases below to MUSC:
  - CT – Cases requiring ventricular assist device
  - Ortho – major trauma, spinal cases, complex shoulder cases.
  - GU – Cryosurgery, Brachytherapy, Lithotripsy
  - ENT – Skull Base surgery, Neuro-otolaryngology, Acoustic Neuromas, Vascular Malformations, Allergy specialists.
  - Vascular – Thoracic-abdominal aneurysms, stent grafts/ aortic endografts
  - General Surgery – Pancreatic cases (whipple), major trauma, liver resection
  - Podiatry – inpatient complex cases (fusions, external fixations, and acute fractures).
  - Ophthalmology – Macugen injections, focal laser, Goldman refraction, & acute neuro-ophthalmology

- OBGYN – obstetrics, high risk pregnancies, hydrothermal ablations (HTA)

The surgical ambulatory clinics at the VA should be separate from those of MUSC while the OR's could be common (shared) for both.

*Laboratory/Pathology*
VA services like microbiology were smaller services and sometimes sent special specimens to DHEC (free service). MUSC had a level three lab. Blood bank services are limited at the VA, with the Red Cross in Columbia performing some sub-specialized testing not available at the Charleston VA. MUSC could resolve these complex, cross-match questions without having to send specimens to Columbia and wait for the specially matched blood to be sent back to Charleston.

During the discussion of the laboratory it was noted that the MUSC clinical and AP histological labs have the capacity to handle both work loads. This would provide a central lab. However there would be a need for some basic labs support or blood bank needs on site. Histology specimen prep could also be done in a joint facility. This included cytology.

Maintaining some adjacent/adjoining labs could resolve capacity issues. VA labs needed some upgrades and replacement equipment. The VA could purchase equipment (for Anatomic Pathology) which could be used by MUSC with discounted fees for service in return to the VA. Use of reputable outside labs by VA and MUSC might be cost effective in some instances. MUSC could provide the weekend and after hours coverage for VA labs.

*Radiology*
- Nuclear Medicine and Radiation Oncology could be shared.
- Basic radiology services should be close to the VA patients.
- After hours and weekend coverage could come from MUSC, from a combined MUSC and VA call for professional and technical staffs.
- Specialized procedures and equipment could be shared in a common and convenient location—PET, CT, Mammography, Nuclear Medicine, and interventional suites.

An information system group would file a report in Group 4 that determined the interoperability needs of a combined/shared program. The timing of the need for information system interoperability appears good (approximately 5 to 6 years from now). Discussants were optimistic about using newer databases and "systems" rather than having to adopt the current products at that time. Discussants were optimistic that when Phase 2 is built information systems interoperability can be achieved.

Phase I building of the new MUSC hospital (Heart, Vascular and Digestive Center) would be examined to determine if capacity exists for sharing these facilities with the VA and equipping the new facility in a joint method.

In the adjoining facilities approach ("back to back" facilities), each could have some basic services, for example with the laboratory, MUSC taking the specialized test now sent out, but each doing some basics in "their own facility." Some improvements in service levels are predicted in after-hours ED services, labs coverage, radiology, etc., with sharing.

***Continuing work*** The Shared Clinical Services Workgroup will continue to explore options that recognize and leverage the strengths of both institutions in terms of capital and clinical technical expertise. The initial recommendations of the subgroups on shared services will be forwarded to the Finance Workgroup. The Finance Workgroup will overlay and evaluate various arrangements or models for covering the construction and equipment costs and operational costs for the various options developed by the shared services subgroups. Following the initial cost evaluation of these various financing models, the subgroups will review and comment on the clinical implications of these various arrangements. Each of the subgroups has developed a general outline of clinical sharing in specific areas, but preferred options for each of the various clinical services have yet to be determined.

Financing/Operational Responsibility: Who would build, own and or manage any joint facilities if those are built? Several models or alternative financing arrangements that specify which party will cover capital construction costs, equipment costs and operational costs have been developed by the Finance Workgroup. The VA usually uses a five year payback horizon in its analyses; this may need to be altered in view of some longer term paybacks.

Information Technology: Given that sharing of clinical services also entails the sharing of clinical information, the interface of clinical information technology/systems is critical. How/when interoperability of respective information systems can be accomplished will need to be explored. The VA VistA patient records system is used at all VA hospitals. The underlying technology is almost twenty years old. The VA has some strict federal requirements under VHA Title 38 that surpass the HIPAA standards. These will pose some challenges for the interoperability of a system that might develop under the sharing agreements. Definition of text terms remains a challenge for all systems. The "VistA definition committee" will be addressing this. There is some excitement about the potential for web-based interoperability, and the ultimate possibility for the whole variety of systems to be linked on the web.

Clinical Operations: The discreet management of OR block time will be necessary in surgery. Protocols for scheduling shared OR equipment would also be necessary. If a single OR suite is to be built, a number of additional operational issues will need to be addressed including, the number of rooms needed, as well as the management of pre-op screening clinics, check-in, holding and recovery. Reference laboratory values issues were cited as needing

further discussion and resolution. STAT lab reports were seen as potential points for problems.

**Governance Workgroup**
**Progress Report to the COSG**

***Focus and Scope*** A Mission Statement was developed to help guide the Governance sub-group in its work:

*"The workgroup will recommend a governance model to serve MUSC and VA for management of shared/common services and resources. The workgroup will identify processes considered necessary for appropriate management of the various aspects of this new relationship."*

It was agreed that whatever Governance structure was developed, a basic tenet would be that the new organization would be focused on a long-term relationship and would strive for the mutual benefit of both organizations.

That the new relationship and subsequent organizational structure would only further strengthen the existing strong affiliation and that disincentives would be developed to prevent one organization from pulling out.

The new Governance structure would cover all aspects of the VA-MUSC relationship, excluding Research and Education activities.

***Progress*** The Governance sub-group was formed with equal membership from both VA and MUSC.

The Governance sub-group has held meetings and/or conference calls on the following dates:
August 5, 2005
August 16, 205
August 29, 2005
September 6, 2005
September 13, 2005

The group identified separate task forces to review several relevant areas associated with Governance. They include :

Compliance and Business Integrity
Accreditation Issues
VA Eligibility

It was agreed that some type of over-arching document (Memorandum of Agreement or Memorandum of Understanding) would be developed which would outline the basic operational tenets of the new organization. This agreement would be between VA and the Medical University Hospital Authority (MUHA). To provide consistency, MUHA would represent and speak for both the Medical University of South Carolina (MUSC) and University Medical Associates (UMA).

The group is considering a newly formed organizational structure that would then oversee joint operations. A suggested name for this new organizational structure would be the VA-MUHA Joint Governance Council. It would operate with the following principles:

- A draft Charter for the Joint Governance Council is currently being developed.
- The Council would focus on all operational aspects of the VA-MUHA relationship excluding research and education.
- The primary focus would be on contractual clinical and administrative services.
- A system of checks and balances would be built into the contractual relationships which would allow for agreed upon adjustments and changes in fee schedules (i.e. inflationary indexes, recognized health care inflation factors, etc.).
- A method of dispute resolution to resolve issues which could include mediation as an initial alternative. VA had initial concerns which are currently being reviewed by General Counsel.
- Governance models from recent VA-DoD integration sites (i.e. Las Vegas and Albuquerque) are being reviewed for potential use.
- An exit strategy for both organizations needs to be identified and developed.
- A major issue still to be determined is whether the Joint Governance Council will have advisory or operational authority to make decisions. Concerns with operational authority include undermining the current authority of the VA Director and MUSC President.

There was a general consensus that some level of new federal legislative authority might need to be enacted to achieve these objectives. As the concept begins to become more defined, other governance and legislative issues will become evident.

***Continuing work*** The following are on-going issues for the Governance Workgroup:

- Continued review of VA-DoD Governance models from Las Vegas and Albuquerque for incorporation into the Charter for the VA-MUHA Joint Governance Council.
- Continued analysis to identify and develop action plans to address relevant issues from the task groups (Compliance and Business Integrity; Accreditation; and VA Eligibility).
- As the various facility models are developed (presently there are 4), the Governance sub-group will work concurrently to identify Governance issues and incorporate these into a Governance model.
- Clarify whether the VA-MUHA Joint Governance Council will be advisory in nature, or will have the authority to make operational decisions.

**Legal Workgroup**
**Progress Report to the COSG**

***Focus and Scope*** – The legal workgroup's task is to analyze the models for future collaboration between the VAMC Charleston and the Medical University of South Carolina proposed by the COSG and identify existing legal authorities under which the models may be implemented and, where existing authority is inadequate to implement any aspect of a proposal, determine what legal authority would be required to permit implementation. Additionally the workgroup will advise any of the other workgroups on any questions relating to legal issues that may be necessary to their review. The workgroup has scheduled weekly conference calls. The VA members have also been conducting separate weekly conference calls.

***Progress*** - There are two aspects to this process – review of federal/VA authorities and review of the MUSC/State authorities. It appears that federal authorities are more restrictive and to date our focus has been primarily on VA's authorities. The VA members of the Workgroup have prepared a general summary of VA's Authorities to Acquire or Otherwise Enter into Agreements for the Operation of Medical Facilities, which is included below.

***Continuing Work*** – The workgroup will review the issues identified by the MUSC members. As the COSG refines the collaboration proposals the Legal Workgroup will focus on the particular authorities available/necessary to accomplish the various aspects of each one. We will respond to questions from the Finance Workgroup.

VA's Authorities to Acquire or Otherwise Enter into Agreement for the Operation of Medical Facilities

Authority to Construct, Alter, or Acquire a Medical Facility

Section 8103 of title 38 generally authorizes the Secretary to construct and alter, and to acquire sites. At subsection 8103(a)(2) the Secretary may acquire by purchase, lease, condemnation, donation, exchange, or otherwise any facility (including the site of such facility). The criteria for the authority to exchange are set forth in subsection 8103(c). To exercise the authority to exchange the Secretary must have specific authorization and appropriation for construction of a medical facility and the Secretary must determine that any site acquired for the construction of the medical facility is not suitable for that purpose.

Section 8104 of title 38 establishes the dollar threshold for specific authority. In the instance of a major medical facility project, specific authorization is required for projects exceeding $7 million. In the instance of a major medical facility lease, specific authorization is required for space for use as a new medical facility at an average annual rental of more than $600,000. Section 8104 further provides that no funds may be appropriated for any major medical facility project or any major medical facility lease unless funds have been specifically authorized.

Section 221 of Public Law 108-70 authorizes the Secretary to carry out certain major construction projects as specified in the final report of the Capital Asset Realignment for Enhanced Services (CARES) Commission. The Secretary however cannot carry out the authority until 45 days after reporting to Congress. By letter dated May 20, 2004, the Secretary satisfied that requirement.

The FY 05 Appropriations Act limits the use of the major construction account to the funding of major medical facility projects that have been approved by Congress in the budgetary process (except for advance planning activities). The conference report (H. Rept. 108-792) accompanying the Act indicates that the funds earmarked for CARES projects in the major construction account were for the FY projects listed in Attachment 1 of the May 20, 2004 letter.

Acquisition of Leasehold Interests in Real Property

A lease is defined as a "contract for the exclusive possession of lands or tenements for a determinate period" of time. A lease, therefore, conveys an interest in real property to the lessee, or tenant. Included within this interest are certain rights, such as the right to quiet enjoyment of the leasehold estate, and the right to require that the landlord ensure that the tenant's use is undisturbed. The landlord may or may not have the duty to maintain the property depending upon the terms of the lease. For example, a triple net lease may place the duty of maintenance on a tenant. Should a landlord fail to keep the lease covenants, the tenant has, among other rights, the right to withhold rent, and the right to specific performance. Consequently, an owner of real property who leases that property to a third party, subordinates, or gives up, some of the rights it has in fee during the duration of the leasehold estate.

Leases: VA Inlease

There are several authorities pursuant to which VA may acquire leasehold interests in real property. 38 USC § 8103 authorizes the Secretary to acquire medical facilities "by purchase, lease, condemnation, donation, exchange, or otherwise." 40 USC § 490(h) authorizes the Administrator of General Services to "enter into lease agreements with any person, copartnership, corporation, or other public or private entity, which do not bind the Government for periods in excess of twenty years." This authority was determined to be "in addition and paramount to any authority conferred by any other law [40 USC § 474]", and was delegated to the then-Administrator of Veterans Affairs from the Administrator of General Services in 1983. However, the delegation was limited to the acquisition of leased space for medically related purposes. On September 25, 1996, the Administrator of General Services created the "Can't Beat GSA Leasing Program" which delegated to all Federal agencies the authority to lease their own space. The sole condition placed upon the delegation was that lease-contracting officers be adequately trained. Therefore, both VBA and VHA now have authority to enter into leases for space for periods not to exceed 20 years.

Leases must be competitively procured in accordance with the requirements of the Competition in Contracting Act of 1984 ("CICA"), and the General Services Acquisition Regulation (GSAR), 48 CFR Part 570.

Leases: VA Outlease

VA's authority to outlease medical or medically related space is set forth at 38 USC § 8122. The term of the lease is limited to three years, and unless leased to a public or nonprofit corporation, the consideration for the lease must be money, pursuant to 40 USC § 1302. Leases to public or nonprofit entities may provide for the maintenance, protection, or restoration, by the lessee, of the property leased, as part or all of the consideration for the lease. Proceeds received by VA, minus expenses for the maintenance, operation, and repair of buildings leased for living quarters, must be deposited into the Treasury as miscellaneous receipts.

VA may also outlease space pursuant to its authority to enter into Enhanced Use ("EU") Leases of unutilized or underutilized real property pursuant to 38 USC § 8161 et seq. Section 8162 permits VA, "notwithstanding . . . any other provision of law (other than Federal law relating to environmental and historic preservation) inconsistent with [section 8162]," to lease real property under the Secretary's jurisdiction or control to a private or public entity for a term up to 75 years. The section requires a beneficial redevelopment/reuse of the affected VA property by the lessee that will include space for a VA mission-related activity and/or will provide consideration that can be applied to improve health care and services for veterans and their families in the community where the site is located.

Section 8162(b) admonishes that the Secretary, in selecting the EU lessee (except in the case of selecting a provider of homeless services), must employ selection procedures that he determines will ensure the integrity of the selection process. It also provides that the consideration for the lease must be "fair consideration," as determined by the Secretary, which may be in the form of rental proceeds and/or facilities, services, space, or other "in-kind" consideration. Pursuant to section 8163, the Secretary's decision to lease property under this authority is made only after VA conducts a local public hearing to receive the

views of veterans' service organizations and other interested parties on the lease and its impact. Further, execution of the EU lease is subject to a 45-day advance congressional "notice and wait" period.

Proceeds from the EU lease, after deducting certain related expenses, are deposited into the Department's Medical Care Collections Fund and used to improve health care services for veterans within the geographical area served by the leased site. Proceeds also may be used to reimburse the Department's expenses in developing additional EU leases. 38 USC § 8165.

Sharing of Space: Introduction

VA has authority to acquire or provide health care resources to any entity pursuant to 38 U.S.C. §§ 8151-8153. Prior to the 1996 legislative amendments, 38 USC § 8152 included space within the definition of "specialized medical resources." The amended provisions of 38 USC §§ 8151-8153 broadened the scope of VA's sharing authority. The term "use of space" was specifically included within the scope of "health care resource." Space logically includes medical, clinical, support, or administrative space. Consequently, VHA has the authority to enter into sharing agreements to acquire the use of space, as well as sharing agreements to provide the use of space to affiliates, or other entities, in exchange for payment and/or services. Unlike a lease, however, a sharing agreement entered into pursuant to 38 USC § 8153 does not acquire or convey an interest in real property.

Sharing Agreements: VA "Selling" Space

With the 1996 expansion of VA's authority to enter into sharing agreements for the use of its underutilized space, Congress made it clear that such space could be utilized to its maximum effective capacity, and provide a source of revenue to use for the treatment of veterans. Nevertheless, the situations pursuant to which the sharing authority can be used do not fit neatly within the parameters of real property law. These agreements do not convey an interest in real property, but we have determined that they need not be revocable at the will of the Government. While Section 8153(e) of the revised statute included a

requirement for sharing agreements for the provision or sale of services that veterans receive priority and that such sharing arrangements are certified necessary to maintain the quality of services or to improve services to veterans, the use of space cannot be classified as a service. Therefore, these statutory requirements are not applicable to sharing agreements providing the use of space. Therefore, we conclude that such agreements are not legally required to be revocable at the will of the Government.

Further, there is nothing in either the language of the statute or the legislative history that specifies or limits the term of a sharing agreement. Prior to 1996, VHA policy has set the duration for selling contracts for the use of space at three years (one base year, plus two one-year options). Without any statutory restrictions on term duration, VHA policy has been changed to allow use of space selling agreements for up to 20 years under 38 U.S.C. § 8153. However, that policy provides that an early cancellation clause shall be required for any agreement exceeding 10 years in length to account for circumstances where VA may require use of the space prior to the expiration of the agreement.

Sharing Agreement for Space: VA Buy

38 USC § 8151 specifically authorizes VA to "receive health care resources from" sharing partners. As has been previously stated, space associated with, or determined necessary to support, the furnishing of health care by VA, can be considered a health care resource. However, there are certain operational limitations regarding exercise of the sharing authority to acquire the use of space. As a general rule, unless specifically authorized, agencies are prohibited from entering into multiyear contracts using annual appropriations. 67 Comp. Gen. 190 (1988). For example, 40 USC § 585(h)(2) gives GSA, and consequently, the agencies to whom GSA delegates leasing authority, specific authority to enter into multiyear leases. The sharing statute, however, does not provide such multiyear authority. It does authorize VA to develop simplified acquisition procedures without regard to any law or regulation governing competitive procedures; however, contract duration is not a competitive procedure. We must look elsewhere to determine the allowable duration of sharing agreements. The

Federal Acquisition Streamlining Act, 41 USC § 254c, gives VA and all agencies multiyear contracting authority for up to 5 years. Alternatively, and in accordance with FAR Subpart 17.2, VA could have an acquisition contract consisting of one base year, plus up to four option years. Thus, 5 years is the practical limitation for any sharing contract to acquire the use of space.

Generally, such agreements must be sought on a competitive basis. However, VA can enter into sole-source sharing agreements for the use of space for up to 5 years from affiliates, or from entities associated with affiliates, pursuant to 38 USC § 8153(a)(3)(A). Otherwise, from other sources, competitive procedures would have to be followed to acquire use of space under this authority.

> Another practical limitation concerns improvements of space acquired pursuant to a sharing agreement. The Comptroller General has ruled Government agencies may not substantially improve private property with appropriated funds. Comp. Gen. Dec., B-194031, May 1, 1979. The general rule is that improvements funded by appropriations must be commensurate with the interest that the Government retains in the property. *Id.* A sharing agreement does not convey an interest in property to VA. Therefore, the sharing authority does not authorize VA to fund substantial improvements to the subject space.

Sharing of VA and Department of Defense health-care resources

VA has authority pursuant to 38 USC § 8111 to share health care resources with the Department of Defense. "The term 'health-care resource' includes hospital care, medical services, and rehabilitative services . . . and any other health-care services, and any health-care support or administrative resource." 38 USC § 8111 (g) (4). Each health-care resources sharing agreement shall state that the providing Department be reimbursed in accordance with a uniform payment and reimbursement schedule for the services provided that has been developed by the Secretaries of Veterans Affairs and Department of Defense. Consequently, VA and DoD, under 38 USC § 8111, can share a wide range of health care resources in the operation of a medical facility.

**COSG Finance Workgroup**
**Status Report to the COSG**

***Scope*** The COSG Finance Workgroup is charged with costing out four varying levels of collaboration between MUSC and the VA on three presently available locations. In addition the group is charged with calculating potential cost savings for the VA over the life of the thirty-year collaboration.

To understand the true costs of operating a potential integrated hospital shell over its lifetime of thirty years the COSG finance subgroup is charged with the following:

- Develop and approve a direct method of comparing costs to reconcile for the differing accounting practices of the organizations
- Determine which organization can most cost effectively provide specific collaborative support services
- Calculate the footprint and square footage required by the four collaboration models
- Determine if the four models will fit in the footprint of the three potential sites
- Analyze vehicle access to the three sites
- Analyze current and future medical service requirements of the MUSC and the VA
- Determine current and future parking needs of the VA
- Agree to a discounted exchange of services between the two organizations
- Analyze potential cost savings resulting from the potential purchase of MUSC Phase 1 equipment by the VA in exchange for discounted procedures

***Progress***

- Comparisons of support services (food, laundry, housekeeping)
- Determination of some services to be maintained separately
- Parking needs and structural assessment of county garage
- Analysis of 3 potential sites in light of space needs, building codes and community regulations
- Development of space and pro forma cost calculation models for three new construction models using agreed upon clinical service distribution and current VA cost estimates
- Analysis of certain Phase 1 equipment for determination of possible VA purchase and sharing
- Preliminary results of equipment analysis show potential savings using VA pricing, but like-comparisons are difficult due to add-ons and enhancements to equipment. However, VA purchase obviates need for initial MUSC capital investment
- Potential for joint savings on both sides by sharing support services

- VA construction pricing has increased due to current market conditions

***Continuing work***

- Finalize unit cost comparisons for shared and contracted services
- Reconcile construction cost per square foot estimation differences between VA and MUSC
- Determine final strategy for parking (shared lots or VA only)
- Determine life cycle costs and complete CEA for each model upon receipt of above data
- Craft agreements based on equipment purchasing decisions
- Finalize model and site selection enabling the development of accurate cost estimates for the three models.
- Decision to pursue piggyback contracts for support services (needs legal input)
- Decision to pursue equipment purchases in exchange for in kind services
- Model preliminary clinical integration and ownership of the clinical spaces by either MUSC or VA to allow for the development of accurate operating costs of the four models

COSG and Workgroup Membership Attachment

**Collaborative Opportunities Steering Group**

| *VA* | *MUSC* |
|---|---|
| VHA Co-Leader- Michael Moreland, Director, VA Pittsburgh Healthcare System | Raymond Greenberg, President, MUSC, Co-Leader |
| Brian Heckert, Director, Columbia Veterans Affairs Medical Center | Stuart Smith, MUSC Hospital CEO |
| Walt Hall, VACO Group 3 Lead Counsel | John (Jack) Feussner, MUSC Chair, Department of Medicine |
| Mike Finegan, Director, Buffalo VAMC | Lisa Montgomery, VP for Finance and Administration |
| Carter E. Mecher, Chief Medical Officer, VISN 7 | Joseph (Jerry) Reves, VP for Medical Affairs and Dean College of Medicine, MUSC |
| RADM T K Burkhard, BUMED East, DoD<br>CAPT S Widhalm, DoD | Marion Woodbury, Special Assistant to the President |
| **Staff Support** – Carla Sivek, Rick Mahon | Chris Malanuk, Planner |

**Group 1 - Governance**

| *VA* | *MUSC* |
|---|---|
| Brian Heckert, Director, Columbia VAMC, Co-Leader | Stuart Smith, MUSC Hospital CEO, Co-Leader |
| William Mountcastle, Director, Charleston VAMC | Marion Woodbury, Special Assistant to the President |
| Richard R. Robinson (OGC), General Counsel, VACO | Betts C. Ellis, Hospital Administration |
| Joseph Pomorski, HR Consultant, VHA Management Support Office | John Heffner, Executive Medical Director, Medical University Hospital Authority; Professor |
| Judith Zboyovski, Quality Management Officer, VISN 4 | Reece H. Smith, Compliance Officer |
| Gary M. Baker, Director, Health Eligibility Center | |
| **Staff Support** | **Staff Support** |
| Rick Mahon | Teresa Rogers |

**Group 2 - Legal**

| *VA* | *MUSC* |
|---|---|
| Walt Hall, VA General Counsel, Group 3-Co-Leader | John (Jack) Feussner, MUSC Chair, Department of Medicine, Co-Leader |
| Phillipa Anderson, VA General Counsel, Group 2 | Annette Drachman, Director, Legal Affairs, MUSC Medical Center |
| John Pressly, Asst. Regional Counsel | Joseph C. Good, University General Counsel |
| Ed Bradley, Portfolio Manager, Office of Asset Enterprise Mgmt (OAEM) | Andrea Barrett, Paralegal |
| Michael J. Cunningham, Contracting Officer - VISN 12 | Karen Rae, Director of Managed Care |
| Jodie Babb, Louisville VAMC VA/DoD Sharing Program | Lisa Kindy, Legal Counsel College of Medicine |
| **Staff Support** | **Staff Support** |
| Sharon Snellgrove, Muriel Phillips | Mary Hudson |

**Group 3 - Finance**

| *VA* | *MUSC* |
|---|---|
| Michael Finegan, Director, Buffalo VAMC, Co-Leader | Lisa P. Montgomery, VP for Finance and Administration, Co-Leader |
| Marcia Balonis - CFO, Charleston VAMC | John L. Cooper, Director, Finance |
| Victor V. C. Cruz, Asheville – Medical Care Collection Fund (MCCF) Director, VISN 6 | Karen Rae, Director of Managed Care |
| Lynn Ryan, VISN 16 CFO | Bruce A. Quinlan, Director, University Medical Associates |
| David Bach, VISN 18 CFO | Bo Faulkner |
| **Staff Support** | **Staff Support** |
| Josh Malecki | Celeste Jordan, Janice Pappas |

**Group 4- Targets for Shared Clinical Services**

| *VA* | *MUSC* |
|---|---|
| Dr. Carter Mecher - CMO VISN 7, Co-Leader | Dr. Joseph (Jerry) Reves, VP Medical Affairs and Dean College of Medicine, Co-Leader |
| Cathy Rick, Chief Nursing Officer | Dr. John Heffner, Executive Medical Director, MUHA |
| Contracting: Augustin Davila, VISN 6 CLO | Dr. Bruce M. Elliott, Senior Assoc. Dean for Clinical Affairs, MUSC |
| Linda Fischetti, Management Analyst, OIT-HES / HIS | Ed Cousineau, Associate Dean, MUSC |
| IT: Cliff Freeman, Director VA / VOD Interagency Prog., OIT | Marilyn Schaffner, Administrator, Clinical Services, MUH |
| Dr. Robert Jesse- PCS- National Director for Cardiology | Dr. John Waller, Director, Medical Informatics, MUSC |
| Dr. Ralph DePalma.-PCS-National Director Surgery | Hal Currey, Hospital Project Advisor, MUH |
| **Staff Support** | **Staff Support** |
| Jackie L. McGee | Beverly Carson, Staff |

Mr. Chairman and Committee Members:

My name is Clarence "MAC" McGee. My home is in Berkeley County South Carolina.

Thank you for granting me this opportunity on behalf of my fellow Legionnaires and Veterans of the First Congressional District. I would like to extend appreciation to South Carolina 1st District Congressman Brown and the Veterans Affairs Committee and VA Health Subcommittee for their work on behalf of the Veteran's of this Community, State and Nation

This concerns the proposal of the merger of the Ralph H. Johnson VA Medical Center (VAMC) and the Medical University of South Carolina (MUSC) at Charleston, SC,

The American Legion is the Nation's largest Veterans Service Organization with over 3 million members who contribute millions hours in volunteer work in the VA Hospital in this community and in VA Hospitals around the Nation. The financial and volunteer service to our Nation's aging Veterans is unprecedented, making our VA system more community friendly and providing a needed service.

I have personally been a member of the American Legion for over 29 years, serving as Department Commander and on several National Committees. Presently I serve on the National Legislative Committee.

I am a Military Retiree, having served over 20 years and retiring as a Senior Non Commissioned Officer, with my service to this Nation taking me to many places, including VietNam.

For the past several years the VAMC and MUSC have enjoyed a contractual working relationship to provide services to the Veterans of this community. The VAMC working with MUSC is not a new concept, but it hoped that it is a

continuation and better experience for the Veterans of this community and that they will appreciate a better medical care delivery system.

- We are pleased to note that the Veterans Affairs overall budget has increased 40 percent since 2000, and are anticipating that future funding will keep pace with the needs of a growing and aging Veteran population.
- A local result of the latest Congressional Supplemental Appropriation, which infused additional monies into the Nationwide VA system, will soon be seen in the Myrtle Beach, Beaufort and Savannah VA Clinics through the addition of new administrative personnel that will allow clinical personnel to concentrate on giving medical care to Veterans.
- We are looking at an aging facility at the Charleston VAMC. With the uncertainty of future spending priorities forced on our nation by terrorism and natural disasters such as Katrina, this facility will not be replaced at any time in the foreseeable future. We as Veterans are pleased with any improvement in serving the needs of the Veterans in our Community. To many Veterans, the VAMC is their only means of obtaining medical care and services. These men and women have in many cases paid with their health. Our responsibility to them is a debt that cannot be paid. To give them the care that they deserve, through whatever vehicle, is the right thing to do. The proposal offered in cooperation with the Medical University of South Carolina sounds good. The question that is most often asked of me by Veterans and their dependents is simply, "Will it remain a Department of Veterans Affairs hospital?" Maintaining the identify of that facility is important, and that assurance, along with ample space to transact VAMC and Veterans business

is critical as this transition goes forward, and we, as Veterans, want that assurance from all parties involved in these negotiations.

- Regarding the planned VA Clinic that is being constructed in conjunction with Navy Super Clinic at the Naval Weapons Station, Veterans want absolute assurance that the VA facility will not be taken over by D.O.D. for active duty military to the medical detriment of our Veterans.
- The following concerns voiced by Veterans are very important:
    1. What will be the impact on associated community out-patient clinics such as the VA / Navy Super Clinic just mentioned?
    2. Where there is a patient load conflict between MUSC & VAMC, how will protocol be established, by whom will it be established, and how will it be established? Will it be by the collaborative action of Medical University of South Carolina and VAMC?
    3. Will VAMC have its own pharmacy, especially to be responsive to known and growing out-patient needs?
    4. How will VA co-pay and 3rd party billing be affected?
    5. Will the new MUSC – VAMC relationship improve the delivery of timely medical care? (At present, the waiting time to be seen or to get an appointment at the VA Hospital is excessive).
    6. Will VAMC retain its current 83.5 resident positions?
    7. Will the supervising physicians be Board Certified? (This question arises often).
    8. The final proposal must constitute a substantial improvement over services currently provided the Veterans from the Low Country.

Currently VAMC Charleston contracts with MUSC for specialty services at a cost of approximately $17 million annually. Have we been getting our money's worth to date, and will there be a measured improvement to the VA patients served as a result of this merger?

9. Charleston VAMC has greater experience in providing care to Veterans and represents a familiarity that may be lost if the two merge. The fear is that VA will be swallowed up by this much bigger medical facility and lose its personal touch with the Veteran. Will the present VA staff be incorporated in such a manner that their experience will continue to convey to their VA Patients?
10. Our local Veterans are apprehensive that services will be reduced and healthcare needs unmet if the proposed merger takes place.

- As the Spokesman for the American Legion and the Veterans of this community, we insist that the proposed merger provide all that is included in an improved level of healthcare to our Low Country Veterans who have bourn the battles that have given us the gift of freedom that we all enjoy and who now suffer the physical consequences of their service.

Lyn Dimery
VFW National Legislative Committee
1763 Dick Pond Road
Myrtle Beach, South Carolina 29575

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Committee on Veterans Affairs
Subcommittee on Health
338 Cannon HOB
Washington, DC 20515

Mr. Chairman: Good morning to you and your committee.

First, let me thank you for allowing me to speak here today to present the committee with some questions from my fellow veterans on the proposed collaboration of the Ralph H. Johnson VA medical center and the Medical University of South Carolina.

My name is Lyn Dimery; I was born and raised in Horry County, in the town of Aynor South Carolina.

I joined the United States Air Force after High school and retired after 21 years as a Non-Commissioned Officer (NCO).

I served in Viet - Nam for 20 months which gave me my eligibility to join one of the greatest and oldest wartime Veterans organization in the United States, The Veterans of Foreign Wars of the United States of American (VFW) and on the 29th of this month we will celebrate our 106th anniversary.

Our National membership is over 1.7 million, and 700 thousand in our Ladies Auxiliary. In the year of 2004 comrades and Ladies had over 2 million hours of volunteer services, in our Communities, VA Hospitals, local Hospitals, Nursing homes and Clinics.

Our organization has been serving Veterans and their families for a long time. Our motto is (Help the dead by serving the living.)

I have been a member of the Veterans of Foreign Wars of the United States of American For twenty-five years, and in the year 2000 I had the honor of being elected State Commander of our 18,000.00 members of the Veterans of Foreign wars of the United States in South Carolina.

I served the past 2 years on the National Council of Administration of the Veterans of Foreign Wars of the U.S.
I was appointed to the Legislative Committee this year by the Veterans of Foreign Wars of the United States Commander In Chief.

I have been working with Veterans, active duty service personell and their families for the past twenty-five years.

During this time I have heard lots of complaints and concerns from veterans and their biggest concern is Veterans Health Care.

I'm here today to present some questions from Veterans who use this center that concerns them on the collaboration of the VA Hospital and MUSC.

With your permission I would like to present them at this time and hopefully see them addressed in this process.

a. Is this a sharing agreement?

b. Who's in charge VA or MUSC?

c. Who's paying for all this and will MUSC pay their share?

d. Who gets priority Veterans or civilians?

e. How will returning Veterans from Iraq and Afghanistan how will they be cared for and what priority will they get?

f. Will this VA medical center lose its name or its identity?

g. How will Community Based Out-patient Clinics be affected by this collaboration?

h. How will Veterans who are currently being seen in Community Based Out-patient Clinics who require surgery or in-patient treatment be effected?

Mr. Chairman, thank you and your committee for your time and allowing me to be here and present some of my fellow Veterans concerns on an important issue as this is to all Veterans who use this VA medical Center.

Thank you and God bless our Veterans.

Lyn Dimery
Legislative Committee Member
Veterans of Foreign Wars

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