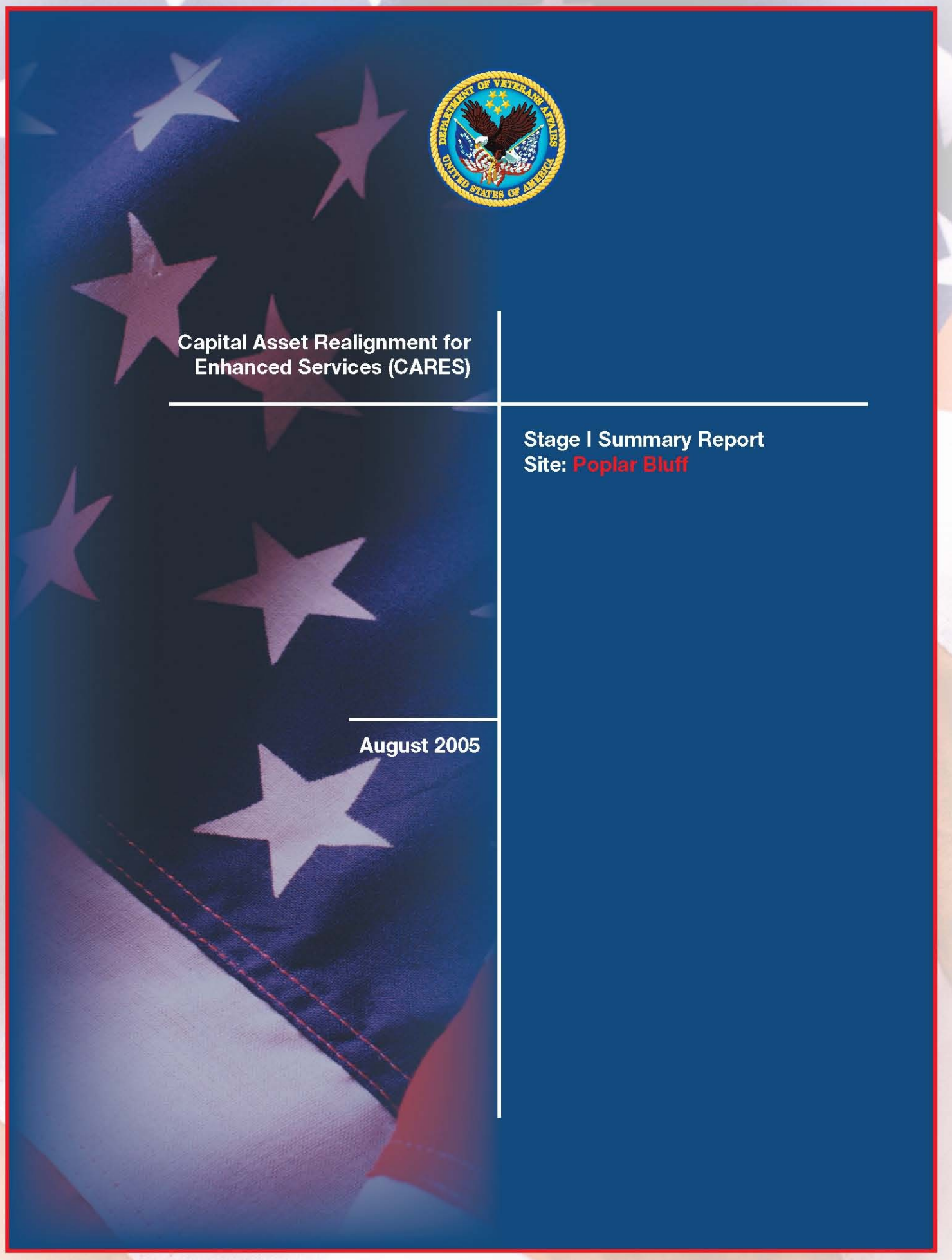

Capital Asset Realignment for Enhanced Services (CARES)

Stage I Summary Report
Site: Poplar Bluff

August 2005

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OVERVIEW AND CURRENT STATE

Statement of Work

Team PwC is assisting the VA to identify the optimal approach to provide current and projected veterans with healthcare equal to or better than is currently provided in terms of access, quality, and cost effectiveness, while maximizing any potential reuse of all or portions of the current real property inventory at the study sites.

For Poplar Bluff, the focus of the study is to determine the cost effectiveness of maintaining inpatient medicine services at the Poplar Bluff VAMC versus contracting the service to a local community provider. Specifically, as memorialized in a memo to the Office of Strategic Initiatives, we are to conduct a cost-benefit analysis, over 30 years, of contracting out *Inpatient Medicine* to a local community provider versus maintaining such care at the Poplar Bluff VAMC.

Summary of Market

The Poplar Bluff VAMC, John J. Pershing VA Medical Center, serves 24 counties in southeast Missouri and six counties in northeast Arkansas. Poplar Bluff is located approximately 150 miles from St. Louis and Memphis. Accessibility to VA medical care is complicated by the large geographic area and lack of adequate public transportation. The facility is comprised of 30.33 acres surrounded on three sides by residential neighborhoods and on the remaining side by commercial areas. The site is a relatively flat open parcel with approximately 10 acres of undeveloped fringe area which could present opportunities for further development or re-development. The site is located near a prime development area which is expected to be enhanced upon completion of a new highway bypass that is under construction.

VISN 15 is made up of Central, East, and West markets. Poplar Bluff is located in the East market.

Stakeholder Concern

Four forms of stakeholder input were received for the Poplar Bluff CARES Study between January 1, 2005 and June 30, 2005; these included: comment forms (paper and electronic), letters, written testimony, and other forms. The greatest amount of written and electronic input was received from veterans. Respondents listed several issues that concern them as it relates to the results of the study including their desire to maintain services at the Poplar Bluff VAMC. Issues of concern listed through oral testimony at the Local Advisory Panel (LAP) also addressed the desire to maintain services at the Poplar Bluff VAMC as well as the desire to maintain relationships with existing VAMC providers.

The following table and figures summarize the definitions and the key concerns raised by stakeholders in their submissions.

Table 1: Definitions of Stakeholder Concerns

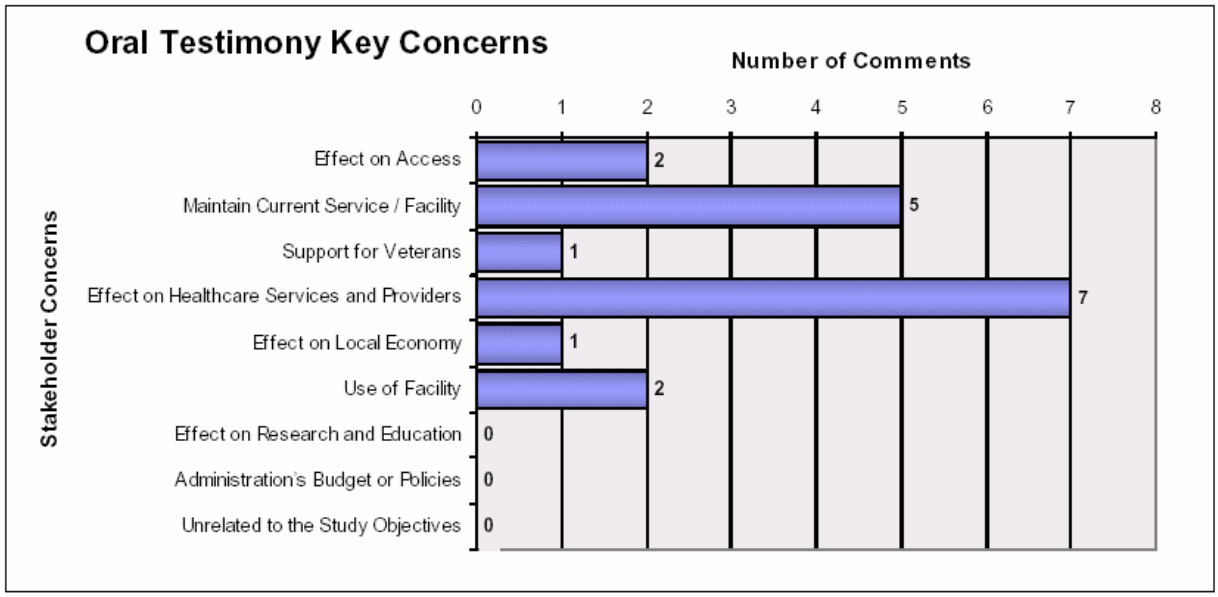
All written submissions from stakeholders were read and sorted according to specified "Key Concerns of Stakeholders". If the author conveyed multiple concerns, each concern was recorded.

The definitions of the categories are listed below:

Stakeholder Concern	*Definition*
Effect on Access	Involves a concern about traveling to another facility or the location of the present facility.
Maintain Current Service/Facility	General comments related to keeping the facility open and maintaining services at the current site.
Support for Veterans	Concerns about the federal government/VA's obligation to provide health care to current and future veterans.
Effect on Healthcare Services & Providers	Concerns about changing services or providers at a site.
Effect on Local Economy	Concerns about loss of jobs or local economic effects of change.
Use of Facility	Concerns or suggestions related to the use of the land or facility.
Effect on Research & Education	Concerns about the impact a change would have on research or education programs at the facility.
Administration's Budget or Policies	Concerns about the effects of the administration's budget or other policies on health care for veterans.
Unrelated to the Study Objectives	Other comments or concerns that are not specifically related to the study.

Analysis of Oral Testimony Input Only (Oral Testimony at LAP Meeting):

The breakout of "Key Stakeholder Concerns" that were expressed during Oral Testimony for the Poplar Bluff study site is as follows*:



* Note that totals reflect the number of times a "key concern" was raised by a stakeholder. If one stakeholder addressed multiple "key concerns", each concern is included in the totals.

Current Status Summary

The current state describes the condition or set of circumstances for the Poplar Bluff VAMC at the beginning of the review period (2003). PricewaterhouseCoopers reviewed a range of documents on the existing condition and operations at Poplar Bluff provided to it by the VA to gain an understanding of the current level of activity and conditions at the Poplar Bluff campus. PricewaterhouseCoopers conducted onsite interviews and toured the Poplar Bluff facility to assess the current state.

Costs

The following summarizes the current state with respect to the cost of providing inpatient care at the Poplar Bluff VAMC. FY 2003 costs were provided by the VACO and obtained from the VA's Decision Support System.

For FY 2003 the VA obligated a total of $53.7 million[1] to the operation of the Poplar Bluff campus. This was made up of:

[1] VA Internal Financial Decision Support and Management Systems, data abstracted by VSSC.

Table 2: Current state of cost of providing inpatient care at the Poplar Bluff VAMC

Type of obligation	FY 2003	% total
Direct medical care	$ 35,071,510	65%
Administration and other overhead	$11,109,662	21%
Facilities management, maintenance and similar	$7,519,624	14%
Total FY 2003	**$53,700,796**	**100%**

These costs, however, include the allocation of central VA and VISN overhead as well as costs, such as pharmacy that will not change irrespective of the options being considered. For the purpose of PricewaterhouseCoopers' financial analysis, the VA has provided PricewaterhouseCoopers with a sub-set of these costs. These are the directly attributable costs of care and operation of the Poplar Bluff campus (i.e. excluding allocated costs and costs that would occur irrespective of option). These totaled about $38 million in FY 2003. The VA's Decision Support System provides these directly attributable costs in the form of variable (per unit of care), fixed and indirect costs for each facility being studied by each of the Cares Implementation Categories (CIC) used across PricewaterhouseCoopers' studies. The definitions of each of these types of cost categories are as follows:

- **Total Variable (Direct) Cost**: The costs of direct patient care that vary directly and proportionately with fluctuations in workload. Examples include salaries of providers and the cost of medical supplies. Variable Direct Cost = Variable Supply Cost + Variable Labor Cost. The cost of purchased care is considered variable direct costs.

- **Total Fixed Direct Cost**: The costs of direct patient care that do not vary in direct proportion to the volume of patient activity. The word "fixed" does not mean that the costs do not fluctuate, but rather that they do not fluctuate in direct response to workload changes. Examples include depreciation of medical equipment and salaries of administrative positions in clinical areas.

- **Total Fixed Indirect Cost:** The costs not directly related to patient care, and therefore not specifically identified with an individual patient or group of patients. These costs are an allocation of the total other costs (i.e. not direct costs) associated with the operation of the Poplar Bluff campus. These costs are allocated to individual medical departments through the VA's existing indirect cost allocation process. Examples of such indirect cost include utilities, maintenance, and administration costs.

The following table indicates the current proportion of variable direct, fixed direct, and fixed indirect costs for providing inpatient medicine and observation and all other care at Poplar Bluff. This table provides insight into the magnitude of the cost for providing inpatient medicine and observation services at Poplar Bluff.

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Table 3: Current proportion of variable direct, fixed direct, and fixed indirect costs for providing inpatient medicine and observation and all other care at Poplar Bluff

CIC Category	Variable Direct Costs	Fixed Direct Costs	Fixed Indirect Costs	Total
Inpatient Medicine	**34%**	**18%**	**12%**	**21%**
All Other	**66%**	**82%**	**88%**	**79%**
Total	100%	100%	100%	100%

The operating costs for the baseline and each BPO are a key input to the financial analysis. They enable adjustments to the costs to be made for each BPO that relate to the operational changes identified for each BPO.

The facilities on the Poplar Bluff site require significant investment in maintenance and replacement to the plant over the next few years. The VA's Capital Asset Inventory systems identify that an investment totalling some $16.3 million is required to address current known issues. The largest single item is $12 million to replace air handlers serving the main hospital building. The current system was installed in early 1978 and is in questionable condition. The site facility management team recommends that a complete new HVAC system needs to be provided for the main hospital building and have provided an estimate of $12 million for this item alone. The remaining $4.3 million is spread across the campus but the bulk of investment is required in building No.1, the main building.

Financial Analysis

The study scope for Poplar Bluff is to focus on conducting a financial analysis, based on a 30-year life cycle analysis, of contracting out inpatient medicine to a local provider versus maintaining such care at the Poplar Bluff VAMC. Therefore, the Poplar Bluff financial analysis involved analyzing certain relevant inputs, such as the cost per bed day of care (BDOC), and generating specific outputs that provide a direct comparison between the baseline option and the option of contracting care.

Inputs

The following inputs were analyzed:

Current and Forecasted Services to Be Provided

Initially, the current and forecasted service mix was analyzed to determine what inpatient services are currently and are forecasted to be provided in the future. With the exception of some inpatient cardiology services, the service mix was predicted to remain the same. The potential increase in inpatient cardiology services is a direct result of the recent hiring of a new cardiologist to the Poplar Bluff staff.

Current and Forecasted Workload

In order to understand the healthcare utilization trends in the Poplar Bluff area, the utilization for healthcare services, and particularly inpatient medicine services, was forecasted by the VACO for 20 years using 2003 data as the base year and forecasting through 2023. Team PwC used workload data provided by VISN 15 and approved by VACO that forecasts a steady decrease in the demand for inpatient services. While the CARES Decision document states that there is a marginal decline from 16 to 11 beds, actual utilization data as provided by VISN 15 and the VACO results in a different set of bed need numbers. The decrease in demand results in a decrease in bed need from thirty-five (35) to twenty-one (21) beds. For HC-2 (contracting care to the local community provider), all inpatient medicine is contracted out for the entire forecasted bed need.

VA Current Unit Cost of Care and Estimated Future Unit Cost of Care

As noted above, PricewaterhouseCoopers estimated the variable, fixed and indirect costs for inpatient medicine at Poplar Bluff. Costs by CIC, without depreciation and overhead, were provided by VACO, as previously described. Variable unit costs of care (unit costs) were multiplied by forecasted utilization and added to the fixed costs to estimate the future costs of care. The cost per BDOC for the Poplar Bluff VAMC was obtained from DSS data and the cost of contracted care was obtained from Fee Package data based on the VA's actual experience in Poplar Bluff VAMC and VISN 15.

HC-2 (contracting care to the local community provider) would involve the mothballing of the Inpatient Medical Ward and related facilities. However, since these are situated within the main hospital building there would be limited opportunity for the VA to make significant savings, other than costs directly related to inpatient care, to offset the costs of the contracted service. PricewaterhouseCoopers has assumed that the VA would be able to save all variable direct costs, 90% of the fixed direct costs and only 10% of the indirect fixed costs associated with inpatient medicine.

Forecasted Facility and Equipment Investment Requirements

The forecasted facility and investment costs over the 30 year period to account for the costs of maintaining the current facility were analyzed. In particular, the cost of replacing the existing air conditioning unit ("chiller") was obtained and determined to be incurred in both the baseline option and HC-2 (contracting care to the local community provider).

Outputs

Cash Flow Estimate

This is the annual cash flow calculated by the BPO Financial Analysis Tool associated with the implementation of a particular business plan option. The Cash Flow Estimate includes variable

costs (e.g. costs per BDOC), VA investments to maintain the building (e.g. the cost of replacing the existing AC unit), anticipated revenues (e.g. leasing arrangements with outside parties) and other related cost items. To ensure the appropriateness and consistency of projecting cash-flows that involve costs with a range of varying underlying escalation (inflation) rates, all un-escalated costs are first escalated (inflated) using appropriate inflation factors to determine the nominal cost value (in the future) of each line item analyzed. Overall, team PwC found that the real cost for providing care under HC-2 (contracting care to the local community provider) is approximately 9.5% greater (in FY 2003 constant dollars) than the cost for continuing to provide such care at the Poplar Bluff VAMC.

Net Present Costs

Measuring and comparing *Net Present Costs (NPCs)* allows for an understanding of which option appears to be more cost effective, considering both options (baseline and local community provider), their related costs and investment requirements. Specifically, the Net Present Cost is the sum of the present value of the discounted present value of all the annual life-cycle costs associated with a particular business plan option (BPO). In addition, the Net Present Cost is the annual cash flows (costs and revenues) of a BPO discounted using the Discount rate and summed to produce an indication of the BPO's overall costs. NPCs are used to allow options with different implementation timings to be compared on a similar basis relative to the Baseline's and other BPO's net present costs. Overall, we found that the Net Present Cost for HC-2 is approximately 8.9% greater than the Net Present Cost of the baseline or HC-1.

Sensitivity to key cost assumptions

PricewaterhouseCoopers was concerned that the current cost of contracted services may over-estimate the cost that could be negotiated with adjacent community providers and/or could be established through a joint venture. To seek to understand what a market price might be for a larger volume of inpatient care, PricewaterhouseCoopers asked the VA to provide it with data from the VA's discharge database for Poplar Bluff on the CMS Diagnostic Reporting Group (DRG) Case Mix Index, CMS Relative Value Units (RVU), average Arithmetic Mean Length of Stay and numbers of discharges for each standard CMS Diagnostic Reporting Group (DRG) applicable to the Inpatient Medicine discharges at Poplar Bluff VAMC in 2003. This information was fed into both the VA's own Medicare DRG pricing tool and separately assessed by PricewaterhouseCoopers' Healthcare reimbursement specialists to determine the appropriate cost assumptions by DRG of contracted care in the Poplar Bluff area.

The VA's Medicare DRG pricing tool identified an unadjusted average cost of approximately $719 per BDOC for Inpatient Medicine. This does not include Medicare adjustments for graduate medical education, indirect medical education, average wage rates, disproportionate share or capital requirements and therefore this cost is lower than the actual cost the VA would be likely to be required to pay.

CMS reports average Medicare reimbursement costs for each state. Analyzing this information indicates that for the Poplar Bluff case mix and average length of stay, a minimum Medicare reimbursement cost per BDOC of Inpatient Medicine CIC – i.e. before allowance for local rather than state wide factors – could be of the order of $750. The actual cost of contracted care would therefore most likely fall somewhere in the range of $750 - $1,139 ($1,139 being the average cost currently paid by the VA in the region). This analysis is a rough approximation and has been completed solely to determine how likely it would be that the VA would be able to achieve an average charge rate of less than $535 per BDOC of Inpatient Medicine CIC, rather than to provide a definitive estimate of pricing. This analysis appears to indicate that the break even rate is less than three-fourths of the lowest price indication and therefore would be likely to be difficult to secure.

If the VA wishes to determine whether a contracting scenario is feasible whereby community providers would accept rates at the breakeven point, the VA would need to directly engage community providers in some type of discourse or negotiation to determine whether or not such a rate would be achievable.

BPO Designation	Label	Description	Support for BPO Selection
BPO 1 **Comprising: HC-1**	Baseline	Current state forecasted out to 2013 and 2023 without any changes to facilities or programs, but accounting for forecasted utilization changes, and assuming same or better quality.	▪ HC-1 (baseline- retaining inpatient medicine services at the Poplar Bluff VAMC) would maintain the only VA provider inpatient medicine services in a large geographic area (about 100 mile radius). These beds would continue to provide desirable access for veterans in the Poplar Bluff service area. ▪ Under HC-1, quality would remain at least the same and perhaps improve. Assuming that the critical volume of services are provided to maintain adequate quality of care, the recent addition of a cardiologist to the VAMC staff may result in higher levels of care. At the very least, the addition of a cardiologist means that veterans in the Poplar Bluff area will have direct access to inpatient cardiology services and perhaps not have to travel to St. Louis, MO or Little Rock, AR to receive such care. ▪ The per unit cost of care for providing Inpatient Medicine services is quite low at the VAMC of Poplar Bluff as compared to the local community provider. HC-1 would result in maintaining a relatively low per unit cost of care. ▪ Based on the input received from stakeholders, HC-1 would be the most poplar option. Stakeholders cited a variety of reasons they prefer maintaining inpatient medicine care at the Poplar Bluff VAMC including access to care, quality of the care they received and relationships created with the VAMC Poplar Bluff providers and staff. ▪ For Poplar Bluff area veterans, the transfer of inpatient medicine to a local community provider may affect good medical continuity as the transfer of ambulatory to inpatient care would be affected.

BPO Designation	Label	Description	Support for BPO Selection
BPO 2 **Comprising: HC-2**	Local Community Provider	Current state forecasted out to 2013 and 2023 and inpatient medicine services contracted out to a local community provider. All other care to remain at the Poplar Bluff VAMC.	▪ HC-2 results in access to acute care services (inpatient medicine) that are at least equal to the access that Poplar Bluff area veterans experience currently.

EVALUATION SYSTEM

The evaluation system below is used to compare BPOs to Baseline BPO

Indicator	*Description*
	Access (Primary, Acute, Tertiary)
↑	The BPO has the potential to increase the % of enrollees meeting VA drive time guidelines, per the Primary Care Access or Arcview tool, as compared to the Baseline.
↔	The BPO has the potential for materially the same % of enrollees to meet VA drive time guidelines, per the Primary Care Access or Arcview tool, as compared to the Baseline.
↓	The BPO has the potential to decrease the % of enrollees meeting VA drive time guidelines, per the Primary Care Access or Arcview tool, as compared to the Baseline.
	Quality (Meets Forecasted Need)
↑	The BPO has the potential to provide more appropriate capacity to meet the forecasted need, as compared to the Baseline (i.e. the BPO can accommodate more of the projected demand either through the VAMC or other provider for ALL years 2003 - 2023).
↔	The BPO has the potential to materially the same capacity to meet the forecasted need for medical services, as compared to the Baseline (i.e. the BPO accommodates materially the same level of projected demand through the VAMC or other provider as the Baseline for ALL years 2003 - 2023).
↓	The BPO has the potential to provide less appropriate capacity to meet the forecasted need for medical services, as compared to the Baseline (i.e. the BPO accommodates less projected demand through the VAMC or other provider for ALL years 2003 - 2023).
	Quality (Modern, Safe, Secure)
↑	The BPO has the potential to provide a more modern, safe, and secure environment and improve compliance with standards with respect to the following, as compared to the Baseline: - Layout (viability of proposed physical layout) - Enough space (adequate quantity of space for clinical inventory) - Adjacency (location of service with respect to other services to which it is functionally related) - Code (meets JCAHO, NFPA Life Safety Code or CAP standards) - Accessibility (meets handicap accessibility standards (ADA, UFAS)) - Privacy (meets patient privacy standards) - Major building system condition (per facility score) - Condition of major medical equipment - Security
↔	The BPO has the potential to provide materially the same environment in terms of modern, safe, and secure and materially the same level of compliance with standards (as defined above), as compared to the Baseline.
↓	The BPO has the potential to provide a less modern, safe, and secure environment and reduces the level of compliance with standards (as defined above), as compared to the Baseline.
↓	The BPO results in a more difficult environment for recruiting and retaining staff.
	Ease of Implementation (Riskiness of Implementing the BPO)
↑	The BPO is expected to entail less risk compared to the Baseline and as measured using the risk assessment tool.
↔	The BPO is expected to entail the same level of risk as compared to the Baseline and as measured using the risk assessment tool.
↓	The BPO is expected to entail more risk as compared to the Baseline and as measured using the risk assessment tool.
	DoD Sharing
↑	The BPO is expected to provide greater opportunities for sharing DoD resources as compared to the Baseline.
↔	The BPO is expected to provide materially the same level of sharing DoD resources as compared to the Baseline.
↓	The BPO is expected to provide fewer opportunities for sharing DoD resources as compared to the Baseline.
	One VA Integration
↑	The BPO is expected to provide greater opportunity for the VAMC to integrate with the VBA and NCA as compared to the Baseline.
↔	The BPO is expected to provide materially the same opportunity for the VAMC to integrate with the VBA and NCA as compared to the Baseline.
↓	The BPO is expected to provide less opportunity for the VAMC to integrate with the VBA and NCA as compared to the Baseline.

Special Considerations	
↑	The BPO is expected to provide greater opportunity for the VAMC to be involved in DoD contingency planning, Homeland Security, and/or Emergency Preparedness as compared to the Baseline.
↔	The BPO is expected to provide materially the same opportunity for the VAMC to be involved in DoD contingency planning, Homeland Security, and/or Emergency Preparedness as compared to the Baseline.
↓	The BPO is expected to provide less opportunity for the VAMC to be involved in DoD contingency planning, Homeland Security, and/or Emergency Preparedness as compared to the Baseline.

Use Operating Cost Line in Real Cash Flow	
Operating cost effectiveness (based on results of initial healthcare/operating costs)	
↑↑↑	The BPO has the potential to provide significant recurring operating cost savings compared to the Baseline BPO (>15%)
↑↑	The BPO has the potential to provide significant recurring operating cost savings compared to the Baseline BPO (>10%)
↑	The BPO has the potential to provide some recurring operating cost savings compared to the Baseline BPO (5%)
-	The BPO has the potential to require materially the same operating costs as the Baseline BPO (+/- 5%)
↓	The BPO has the potential to require slightly higher operating costs than the Baseline BPO (>5%)
↓↓	The BPO has the potential to require slightly higher operating costs than the Baseline BPO (>10%)
↓↓↓	The BPO has the potential to require slightly higher operating costs than the Baseline BPO (>15%)
Use Operating Costs - Investment Required Line Plus any large Expenditures from Life Cycle between 2003 and 2019	
Level of expenditure anticipated (based on results of initial capital planning costs)	
↓↓↓↓	Very significant investment required relative to the Baseline BPO (e.g. 2 or more times)
↓↓	Significant investment required relative to the Baseline BPO (e.g. 1-2 times)
-	Similar level of investment required relative to the Baseline BPO (+/- 20% of Baseline)
↑↑	Reduced level of investment required relative to the Baseline BPO (40-80% of Baseline)
↑↑↑↑	Almost no investment required
Use Reuse Line	
Level of Re-use proceeds relative to Baseline BPO (based on results of initial Re-use study)	
↓↓	High demolition/clean-up costs, with little return anticipated from Re-use
-	No material Re-use proceeds available
↑	Similar level of Re-use proceeds compared to Baseline (+/- 20% of Baseline)
↑↑	Higher level of Re-use proceeds compared to Baseline (e.g. 1-2 times)
↑↑↑	Significantly higher level of Re-use proceeds compared to Baseline (e.g. 2 or more times)
Compare option to Baseline Investment Expense. IF Baseline Investment requires large expense that option does not require then an avoidance exists. (For now, use 0-25%, 25 to 50% and more than 50%)	
Cost avoidance (based on comparison to Baseline BPO)	
-	No cost avoidance opportunity
↑↑	Significant savings in necessary capital investment in the Baseline BPO
↑↑↑↑	Very significant savings in essential capital investment in the Baseline BPO
Use Total $	
Overall Cost effectiveness (based on initial NPC calculations)	
↓↓↓↓	Very significantly higher Net Present Cost relative to the Baseline BPO (>1.15 times)
↓↓	Significantly higher Net Present Cost relative to the Baseline BPO (1.10 – 1.15 times)
↓	Higher Net Present Cost relative to the Baseline BPO (1.05 – 1.09 times)
-	Similar level of Net Present Cost compared to the baseline (+/- 5% of Baseline)
↑	Lower Net Present Cost relative to the baseline (90-95% of Baseline)
↑↑	Significantly lower Net Present Cost relative to the Baseline BPO (85-90% of Baseline)
↑↑↑↑	Very significantly lower Net Present Cost relative to the Baseline BPO (<85% of Baseline)

Assessment Summary Compared to Baseline	BPO 2
	HC-2
Health Care Access	↔
Healthcare Quality	
Modern, safe, and secure environment	NA
Meets forecasted service need	↔
Cost Effectiveness	
Operating cost effectiveness	↓
Level of expenditure anticipated	-
Level of re-use proceeds	NA
Cost avoidance opportunities	-
Overall cost effectiveness	↓
Ease of Implementation	
Ability to maintain uninterrupted care	NA
Riskiness of BPO implementation	NA
Wider VA Program Support	
DoD sharing	NA
One-VA Integration	NA
Special Considerations	NA

Acronyms

AMB	Ambulatory
BPO	Business Plan Option
CBOC	Community Based Outpatient Clinic
CIC	CARES Implementation Category
DoD	Department of Defense
FTEE	Full-time employee equivalents
IP	Inpatient
LAP	Local Advisory Panel
OP	Outpatient
MH	Mental Health
VA	Department of Veterans Affairs
VACO	VA Central Office
VAMC	Veterans Affairs Medical Center
VISN	Veterans Integrated Service Network

Definitions

CARES (Capital Asset Realignment for Enhanced Services) – a planning process that evaluates future demand for veterans' healthcare services against current supply and realigns VHA capital assets in a way that results in more accessible, high quality healthcare for veterans.