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***STATEMENT OF  
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BEFORE THE  
COMMITTEE ON VETERANS' AFFAIRS  
UNITED STATES HOUSE OF REPRESENTATIVES  
NOVEMBER 20, 2013***

Mr. Chairman and Members of the Committee:

Thank you for this opportunity to present testimony for the record on the views of DAV (Disabled American Veterans) concerning the Department of Veterans Affairs (VA) and its capital investment programs, including the necessity for Congress to authorize important leases for VA community-based outpatient clinics and other necessary facilities, and to address other capital asset and construction policy issues. This is a very important hearing on a vital subject that in many ways has languished for years. We appreciate your conducting it today.

Mr. Chairman, the Committee titled this hearing, “Building VA’s Future – Confronting Persistent Challenges in VA Major Construction and Lease Programs.” While this title may seem meaningful, newsworthy or topical to the Committee, DAV would differ on your characterization of its focus. We believe that, for years, VA’s path on capital needs, including its proposed leases, has been crystal clear, and only seems “challenging” now because VA persistently has been obstructed by the Office of Management and Budget (irrespective of which party controlled the Administration) and Congress—including the Budget and Appropriations Committees in both chambers—in actually securing the resources VA has consistently and clearly identified as necessary to keep VA’s capital plants and facilities in proper, safe and modern condition for the care and treatment of veterans, including members of our organization, DAV.

Over the years, VA has used a variety of techniques and approaches to identify and justify necessary capital resources, to sharpen these estimates, and to address the doubts and skeptics of VA’s true needs. Nevertheless, any perfunctory review of the end results of these annual efforts would show massive gaps between what was identified by VA professionals in the beginning of the process, what the Administration asked for, and what was ultimately provided by Congress.

In plain language, to remain a viable health care system for the veterans who need VA today and will unquestionably need it in the future, we believe VA now needs a reasonable and sustained flow of billions of dollars in major medical facility construction, minor construction and maintenance and repair funds.

The latest projection (based on VA’s “Strategic Capital Investment Planning” (SCIP) process, demonstrates that VA could easily spend over \$50 billion or more over the next decade in all infrastructure accounts to modernize, renovate and replace health care facilities. Some of VA’s facilities are over 100 years old, and the facility average age is over 60 years. We estimate that VA’s

current “ten year plan” for modernization of capital facilities under the SCIP approach would require 67 years or even longer to achieve its goals if Congressional funding for these purposes continues at its recently observed pace. We are unsure why, even facetiously, VA would entitle the current plan a “ten year plan,” given this outlandish prospect.

As a partner organization of the *Independent Budget*, DAV has regularly endorsed and recommended annual appropriations for major and minor medical capital facility improvements well in excess of what Administrations have requested, or that Congresses have provided in appropriations. Typically, over this decade, Congress has provided about one-fourth, more or less, of the amounts identified by our estimates. We believe that, absent sufficient funding, situations such as embraced by the title of this hearing are inevitable now, and will be repeated well into the future.

Mr. Chairman, it is no secret that that the IB veterans service organizations have always relied on VA’s internal estimates in making our infrastructure funding recommendations to both the Administration and Congress, because we believe professional staff in these VA offices and facilities know their programs better than anyone, and are making estimates based on intimate knowledge of the system and its needs, professional principles associated with capital improvements, and known construction standards and costs. If these internal needs are overblown or inflated, are the “experts” in the Office of Management and Budget (OMB) or on Capitol Hill justifying their decisions to gut VA’s estimates and to fund these programs at lesser levels? How is it that VA develops a solid, professional and defensible budget for infrastructure, only to have it reduced without any justification or explanation? DAV believes this is also an oversight question worth the Committee’s efforts, to determine how these decisions are made, and by whom.

## **Leased Facilities**

One of VA’s cornerstones in capital planning is leasing. Leasing community-based facilities is a proven, cost-effective way for VA to extend access and provide services without the need to build expensive government-owned facilities. Such leased facilities are an important element in the future of VA health care, discussed further in this testimony, and we appreciate the hoped-for resolution of the paralysis that has suspended this key program for over a year. VA’s current leasing plan calls for a little over \$2 billion to be committed to leases over the next 10 years. VA leases properties to use for each administration within VA, ranging from community-based outpatient clinics (CBOC) and a variety of health care centers, to research, warehouse space and other valuable uses. The cost of these leases does not fall under VA construction accounts, but is accommodated from within each administration’s or other VA offices’ operating accounts.<sup>1</sup>

Well known to this Committee, in a 2012 policy shift, the Congressional Budget Office (CBO) changed its accounting practices on how major facility leases are to be funded, effectively halting Congressional authorization of future VA leases. Currently, there are 28 major capital leases, totaling nearly \$247 million, for which VA had requested Congressional authorization. These leases have been in limbo. This backlog of leases will only grow as existing leases expire. Lack of reauthorization could result in closures of current VA clinics, and newly proposed clinics cannot be activated without authorization. Inaction will lead to increased costs associated with longer travel times or the need to authorize fee-basis care that otherwise would be provided through such leased CBOCs. Access to care will also decline as veterans will be forced to travel farther and wait longer for the care they need.

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<sup>1</sup> FY 2012 Budget Submission, Construction and 10 Year Capital Plan, February 2011, Vol. 4 of 4, p. 8.2-85.

We sincerely compliment the Committee and your professional staff in working to resolve the lingering dispute of the past year that delayed VA in opening new community-based clinics through the well-established and popular leasing program that has been used to extend VA care to hundreds of communities over the past 25 or more years. Over that period, Congress improved VA health care access and patient satisfaction by authorizing and funding nearly 900 VA community-based outpatient clinics, the vast majority having been in leased space rather than government-owned facilities. These clinics have provided local, convenient and cost-effective primary care for millions of veterans.

While we take no position on which specific community clinics and other VA facilities should be authorized in the new draft bill the Committee is considering today, we support the bill developed by the Chairman and urge its positive consideration by the Committee and the full House at the earliest possible date, so that the Senate can act on it this year. Millions of veterans already benefit from the cost-effective and commonsense approach of VA's leasing facilities, and we appreciate the hard work of your professional staff in negotiating a potential resolution of what appeared only days ago to be an insoluble problem, that pitted the CBO against the OMB in a seemingly endless dispute about how these clinics should be treated in the budget.

### **VA "Challenges," or Loss of Talent?**

Another concern you articulated in your invitation letter is VA's "persistent challenge" in managing the construction of several new VA medical centers. It is true that until these new facilities were authorized, VA had not completed construction of a new VA medical center since 1994. In all probability, hundreds of talented architects, engineers and other key staff in VA Central Office and facilities who had worked within VA in years previous to 1994 to build those facilities (Minneapolis, Portland, Baltimore, Richmond, West Palm Beach) departed their VA employment, because Congress in its wisdom determined not to authorize further VA major medical facilities as replacements for VA's aging facilities. We do not blame those professionals or VA for these significant resignations and the subsequent loss of talent; but we have little doubt that the departures of these professionals affected VA's ability to design, manage and build VA's newest facilities. They certainly did.

Mr. Chairman, one of your predecessors as Chairman in effect accurately predicted the current situation about six years ago, and based his concern on his view that so many of VA's staff who had been involved in managing new construction in the 1980's and 1990's had departed that he doubted VA would be successful in building new facilities that Congress was considering to authorize at that time (Denver, Las Vegas, New Orleans and Orlando were specifically identified as among his concerns). It is no surprise to DAV today that VA has been experiencing difficulties in managing the projects now identified by this Committee as being of concern because of poor execution and cost overruns. However, we believe VA is making an honest and straightforward effort to learn from its past mistakes, and will in fact surmount the problems that have surfaced in recent times. The suggestion you made in your invitation letter that the Army Corps of Engineers or another federal agency could step in and improve this complex VA program is an unproven theory, and an unlikely scenario in our judgment.

Considering the example of the Corps, the recently completed construction of the Fort Belvoir Army Community Hospital, the Army's newest facility and one of the world's most expensive hospitals, was managed by the Army Corps of Engineers. That \$1.3 billion construction

project was roundly criticized by outside reviewers for both delays and excessive costs, similar to the types of criticisms levied at VA over cost overruns at the Orlando and Denver facilities. We do not envision an Army Corps of Engineers takeover of VA construction to be in the best interests of veterans, or of VA's capital programs. We know of no other federal agency with the expertise to build hospitals or other types of health care facilities suitable for veterans' care.

Mr. Chairman, it is important to remember that VA facilities are the primary places where our veterans receive their care, and these facilities are just as important entities as the physicians, nurses and myriad technicians who actually deliver their care. Every effort must be made to ensure these facilities remain safe and sufficient environments to deliver care to veterans. A VA budget that does not adequately identify and fund facility maintenance and construction reduces the timeliness and quality of care for veterans.

As indicated above, VA's most recent iteration of facility planning mechanisms is SCIP. SCIP is described by VA as a tool to help VA make more informed decisions on its competing capital investment needs, in a severely constrained funding environment. One key element that appears to be missing from the SCIP criteria is a comprehensive assessment of the resources that exist outside of the VA through existing contracts and sharing agreements, and how those arrangements may affect VA's need for VA-managed facilities. Unlike VA-built and leased space, contracts can be amended, cancelled or situated differently to respond to demographic changes and needs of veterans. VA-owned facilities are more static and inflexible. This is especially relevant and important to VHA because VA, Congress and the IBVSOs have increasingly supported leveraging community resources to provide accessible care to veterans in rural, remote and underserved areas where VA simply cannot justify government construction. Without an unambiguous understanding of the health care resources that exist outside of VA, the Department is greatly challenged to make sound decisions on capital investments and right-sizing its inventory for the near-, mid- and long-term planning vistas. Another apparent flaw of SCIP is the lack of transparency on the costs of VA's future real property priorities that hinders VA's ability to make informed decisions. This was among the findings in a report that the Government Accountability Office (GAO) issued on January 31, 2011, entitled *VA Real Property: Realignment Progressing, but Greater Transparency about Future Priorities is Needed*.

The IBVSOs fully support the GAO's recommendation to enhance transparency by requiring VA to submit an annual report to Congress on the results of the SCIP process, subsequent capital planning efforts, and details on the costs of future projects. Mr. Chairman, your draft bill's inclusion of a new reporting requirement is consistent with the need for greater transparency in leased facilities, and we agree with the sentiment expressed in the bill. We believe a similar detailed annual reporting requirement should be imposed on all VA SCIP-prioritized projects.

The IBVSOs also support the inclusion of new criteria that considers resources that are available to VHA through existing contracts and sharing agreements. We urge a more rigorous analysis by VA that informs the priority list of projects in SCIP.

Quality, accessible health care continues to be the focus for DAV and the IBVSOs. To achieve and sustain that goal, large capital investments must be made, and should not be avoided or obscured with partial funding as is the present case. Presenting a well-articulated, transparent capital building plan is important, and a feat that VA has actually accomplished fairly consistently, but funding that plan at nearly half of the prior year's appropriated level and at a level that is only 25

percent of what is needed to close the access, utilization and safety gaps is not responsive, and in fact impedes VA's mission to care for veterans.

As indicated above, decades of underfunding by one Administration and Congress after another have created a major medical facility construction crisis that has reached a scope of \$19-\$23.3 billion in unmet needs. Currently, 21 VHA major construction projects have been partially funded by Congress dating back to 2007. In the Administration's budget request for the current year (FY 2014, still to be enacted by Congress almost two months into the year), VA requested funding for only one new project.<sup>2</sup> The total unobligated amount for all currently-budgeted major construction projects exceeds \$2.9 billion.<sup>3</sup> Yet the total budget proposal for FY 2014 major construction accounts was less than \$342 million, a small fraction of needed funds.

As summarized earlier, to complete existing approved projects and to close current and future gaps, VA needs to invest at least \$23.2 billion<sup>4</sup> over the next 10 years. At current requested funding levels, it will take more than 67 years to complete VA's "10-year plan." In the short term, VA must begin requesting and Congress must begin providing funding for major construction at levels that at least begin to address this backlog, such as a level of \$1 billion or more in major construction funding in FY 2015 as a modest down payment on the backlog. A funding level of this magnitude would enable VA to close the most severe safety gaps and complete funding on the longest-standing and previously approved major projects.

### **Minor Construction Accounts**

To close all the minor construction gaps within a 10-year timeline, VA would need to invest between \$6.8 billion and \$8.3 billion.<sup>5</sup> For several years, VA minor construction was funded at a level to actually meet its 10-year goal, and we appreciated that commitment by Congress. However, over the past two years (2012-2013), Congress has acceded to the Administration's drastic funding reductions in minor construction requests. However, VA proposed \$715 million in this account for FY 2014, an amount that comes close to the level needed annually to close all gaps within ten years.

The IBVSOs believe that minor construction accounts can be brought back on track by investing approximately \$831 million per year over the next decade to close existing gaps and prevent an unmanageable situation.

Another unmet and significant challenge for VA in infrastructure is associated with VA's national Medical and Prosthetic Research Program. An independent analysis commissioned by VA at the behest of the House Appropriations Committee, published in 2012 after an unconscionable delay, clearly showed a need for VA to invest almost \$800 million in upgrades, renovations and outright replacements of VA research laboratories and associated research facilities. While we realize these funds will not materialize immediately given VA's other needs as outlined in this testimony, we urge Congress to begin to address needs in VA's research program by appropriating new funding for both major and minor construction projects, and for additional maintenance, at minimum to address the most serious deficiencies identified in the research infrastructure report.

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<sup>2</sup> Ibid. p. 8.2-12

<sup>3</sup> Ibid. p. 2-49

<sup>4</sup> Ibid. p. 1-4

<sup>5</sup> Ibid. p. 1-4

## **Nonrecurring Maintenance Accounts**

Even though non-recurring maintenance (NRM) is funded through VA's Medical Facilities Appropriation account, and not through a construction appropriation, it, too, is critical to maintenance of VA's capital infrastructure. NRM embodies the many small projects that together provide for the long-term sustainability and utility of VA facilities. NRM projects are one-time repairs, such as modernizing mechanical or electrical systems, replacing windows and equipment, and preserving or replacing roofs and floors, among other routine maintenance needs. Nonrecurring maintenance is a necessary component of the care and stewardship of a facility. When managed responsibly, these relatively small, periodic investments ensure that the more substantial investments of major and minor construction provide real value to taxpayers and to veterans as well.

With ever-shrinking requests from the Administration and compliant appropriations from Congress in recent years, VA finds itself slipping farther behind in addressing a slew of recognized safety, utilization, and access deficits associated with infrastructure. To simply maintain VA infrastructure in its current (and often substandard) form, VA's NRM appropriations account could easily justify \$1.35 billion per year, based on the estimated plant replacement value the IBVSOs have calculated. The account is currently being funded at \$712 million, about half of what is needed. Even more funds will be needed to prevent the current documented NRM backlog of \$19 billion to \$23.3 billion from growing to more staggering levels. Also, to close the gaps in safety, access and utilization, VA will need to invest between \$27 and \$33 billion more in major and minor construction, and \$2 billion or more in leasing.

## **Plant Replacement Value**

The vastness of VA's capital infrastructure is rarely fully visualized or understood. VA currently manages and maintains more than 5,600 buildings and almost 34,000 acres of land with a plant replacement value (PRV) of approximately \$45 billion. Although VA has worked to reduce the number of critical infrastructure deficits, there remain more than 3,900 gaps that will cost between \$54 and \$66 billion to close, including \$10 billion in activation costs for new facilities that will be needed downstream.<sup>6</sup>

VA is falling behind in closing current NRM safety, utilization and access gaps. Just to maintain what VA manages, in the condition that it is in, VA's NRM account should be funded at \$1.35 billion per year, based on the IBVSO estimated PRV. It is currently being funded at about one-half of need, at \$712 million per year. More funds will need to be invested to prevent the \$22.4 billion NRM backlog<sup>7</sup> from growing even larger.

The IBVSOs believe VA should develop a PRV schedule and publish its results. Adding the PRV to the SCIP will allow VA to more accurately determine the appropriate amount to request for NRM and objectively determine when a facility becomes more costly to maintain than to replace. Using PRV as a tool, VA can more accurately determine the annual funding levels needed for NRM by facility, allowing for the reduction in the NRM backlog and fully funding future needs in a way that would be the most cost effective. The industry goal for NRM is around two percent of the PRV.

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<sup>6</sup> Department of Veterans Affairs, FY 2013 Budget Submission Construction and 10 year Capital Plan, Vol. 4 of 4, February 2012, p. 8.1-1.

<sup>7</sup> Department of Veterans Affairs, FY 2013 Budget Submission Construction and 10 year Capital Plan, Vol. 4 of 4, February 2012, p. 1-4.

At that rate, facilities can operate for 50 years or more without outspending what it would cost to replace them. Knowing what percentage of the PRV is being spent will allow Congress and VA to take a longer view of capital planning, and to visualize when a facility will need to be replaced.

### **In Conclusion**

Mr. Chairman, in summary, if Administrations and Congresses properly fund VA's infrastructure needs into the future, in cognizance of this testimony that the work of the IBVSOs represents, and if VA adopts some of the important recommendations in the *Independent Budget*, we believe much of VA's deficit in capital infrastructure can be addressed, and its methods can be improved. However, due to the decades of underfunding that has occurred in addressing VA's capital needs, we see no "quick fix" to solve VA's current capital crisis. Years of benign neglect must be replaced with years of dedicated and predictable investments in infrastructure, if Congress intends to ensure that VA remains a viable provider of health care services in the future.

Mr. Chairman and Members of the Committee, this completes DAV's testimony, and we appreciate the opportunity to present it for the Committee's consideration.