RAYMOND KELLEY, DIRECTOR NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

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STATEMENT OF RAYMOND KELLEY, DIRECTOR NATIONAL LEGISLATIVE SERVICE VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS UNITED STATES SENATE

WITH RESPECT TO

VA'S BUDGET REQUEST FOR FISCAL YEAR 2013

WASHINGTON, D.C. February 29, 2012

MADAM CHAIRMAN AND MEMBERS OF THE COMMITTEE:

On behalf of the more than 2 million men and women of the Veterans of Foreign Wars of the U.S. (VFW) and our Auxiliaries, I would like to thank you for the opportunity to testify today. The VFW works alongside the other members of The Independent Budget (IB)- AMVETS, Disabled American Veterans and Paralyzed Veterans of America- to produce a set of policy and budget recommendations that reflect what we believe would meet the needs of America's veterans. The VFW is responsible for the construction portion of the IB, so I will limit my remarks to that portion of the budget.

With an infrastructure that is more than 60 years old, the Department of Veterans Affairs (VA) has a monumental task of maintaining and improving its vast network of facilities to ensure the Veterans Health Administration (VHA) can provide accessible, high-quality health care to our nation's veterans.

Currently, VA owns 5,300 buildings and manages more than 800 leases. In 2005, VA began using the
Federal Real Property Council (FRPC) Tier 1 performance measures to assess its capital portfolio goals.1
The two measures that directly affect patient services are utilization and condition. In 2004, VA's utilization was at 80 percent, well below capacity. That utilization grew to 121 percent in 2010, and is projected to grow even more in the coming years. During the same time period, the condition of VA's infrastructure decreased from 81 percent to 71 percent.2 These trends show that funding for the next few years will be critical for VA to fulfill its mission.

VA has developed the Strategic Capital Investment Plan (SCIP) to address the critical deficiencies in its infrastructure. SCIP uses six criteria to assess deficiencies, or gaps, in its ability to deliver efficient, high- quality, accessible services and care for veterans. . The six gap

criteria are access, utilization, space, condition, energy, and other (which includes safety security, privacy and seismic corrections).3 It was also determined that to close all these gaps it would cost between $53 billion and $65 billion.4

To determine and monitor the condition of its facilities, VA conducted a Facility Condition Assessment
(FCA). These assessments include inspections of building systems, such as electrical, mechanical, plumbing, elevators, and structural and architectural safety; and site conditions consisting of roads, parking, sidewalks, water mains, water protection. The FCA review team can grant ratings of A, B, C, D, and F. Assessment ratings A through C conclude the assessed is in new to average condition. D ratings mean the condition is below average and F means the condition is critical and requires immediate attention. To correct these deficiencies, VA will need to invest nearly $10 billion.5 To close the gaps in
access, VA will need to invest between $30 billion and $35 billion dollars in major and minor construction and leasing. The remaining $20 billion is needed to close the remaining nonrecurring maintenance deficiencies.

Major Construction Accounts:

By estimation of the Department of Veterans Affairs, the cost to implement all currently identified gaps in major construction, Congress will have to authorize and appropriate between $20 billion and $24.5 billion over the next 10 years. Currently, there are 35 major construction projects that are authorized, dating back as far as 2004. Only three of these projects are funded through completion. The total unobligated amount for all currently congressionally budgeted major construction projects is $2.8 billion.6 Yet the total
funding requested for FY 2012 major construction accounts was only $725 million.

At this level of funding, it will take VA more than 25 years to complete its current 10-year capital investment plan. The Independent Budget veterans service organizations (IBVSOs) understand that fiscally difficult times call for spending restraints, but without quality, accessible medical centers, VA will not be able to deliver quality, accessible care. The IBVSOs recommend $2.8 billion to complete all partially funded and future major construction needs to close all identified gaps by 2021.

Minor Construction Accounts:
To close the minor construction gaps within its I 0-year timeline, VA will need to invest nearly $8 billion in Veterans Health Administration minor construction alone.7 Minor construction projects allow VA to address issues of functional space within existing buildings and improve facility conditions at a cost of less than $10 million. In past years VA and Congress requested and appropriated nearly I 0 percent of the total need to close the minor construction gaps. However, the Administration and Congress decreased funding for minor construction by about $250 million over the past two years. If this rate of investment is continued, it will take more than 16 years to complete all current minor construction gaps. Congress and VA must put minor construction back on track by investing 10 percent of the total cost to complete the
10-year minor construction plan. With this in mind, the IBVSOs recommend $969 million in FY 2013 to achieve this goal.

Nonrecurring Maintenance Account:

Even though nonrecurring maintenance (NRM) is funded through VA's Medical Facilities account and
not through the construction account, it is critical to VA's capital infrastructure. NRM embodies the many small projects that together provide for the long-term sustainability and usability of VA facilities. NRM projects are one-time repairs, such as modernizing mechanical or electrical systems, replacing windows and equipment, and preserving 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. Accordingly, to
fully maintain its facilities, VA needs an NRM annual budget of at least $2.1 billion.

Given the low level of funding NRM accounts have historically received, the IBVSOs are not surprised that basic facility maintenance remains a challenge for VA. In addition, the IBVSOs have long-standing concerns about how this funding is apportioned once received by VA. Because NRM accounts are organized under the Medical Facilities appropriation, it has traditionally been apportioned using the Veterans Equitable Resource Allocation (VERA) formula. This formula was intended to allocate health- care dollars to those areas with the greatest demand for health care, and is not an ideal method to allocate NRM funds. When dealing with maintenance needs, this formula may prove counterproductive by moving funds away from older medical centers and reallocating the funds to newer facilities where patient demand is greater, even if the maintenance needs are not as intense. The IBVSOs are encouraged by actions the House and Senate Veterans' Affairs Committees have taken in recent years requiring NRM
funding to be allocated outside the VERA formula, and we hope this practice will continue.

Capital Leasing:

The Department of Veterans Affairs enters into two types of leases. First, VA leases properties to use for each agency within VA, ranging from community-based outpatient clinics (CBOC) and medical centers, to research and warehouse space. These leases do not fall under the larger construction accounts, but under each administration's and staff office operating accounts.8

The second type of lease, called enhanced-use lease (EUL), allows VA to lease property they own to an outside-VA entity. These leases allow VA to lease properties that are unutilized or underutilized for projects such as veterans' homelessness and long-term care. Proper use of leases provides VA with flexibility in providing care as veterans' needs and demographics changes.

VA has moved to leasing many of its CBOCs and specialty clinics to increase access of primary and specialty care in local communities as well as a way to be more modular as veterans' demographics change. The IBVSOs see the value in providing quick, accessible health care, but caution a leasing concept that will rely on contracting inpatient care. Not having accessible inpatient care can and has left VA looking for ways to treat veterans in their greatest time of need. As Strategic Capital Investment Planning continues to move forward and more leases are

entered into, some of which may have inpatient alternatives, the IBVSOs will be continue to be vigilant to ensure that VA has viable contingency plans for inpatient care.

EUL gives VA the authority to lease land or buildings to public, nonprofit, or private organizations or companies as long as the lease is consistent with VA's mission and that the lease "provides appropriate space for an activity contributing to the mission of the Department."9 Although EUL can be used for a wide range of activities, the majority of the leases result in housing for homeless veterans and assisted
living facilities. In 2013, VA has 19 buildings or parcels of land that are planned for EUL.10 The IBVSOs encourage VA to continue to improve their transparency of potential EUL properties. Improving dialog
with veterans in the communities will reduce the backlash that often occurs when VA property is being repurposed.

Empty or Underutilized Space at Medical Centers:

The Department of Veterans Affairs maintains approximately I,100 buildings that are either vacant or underutilized. An underutilized building is defined as one where less than 25 percent of space is used. It costs VA from $1 to $3 per square foot per year to maintain a vacant building.

Public Law 108-422 incentivized VA's efforts to properly dispose of excess space by allowing VA to retain the proceeds from the sale, transfer, or exchange of certain properties in a Capital Asset Fund. Further, that law required VA to develop short and long term plans for the disposal of these facilities in an annual report to Congress. With this in mind, VA has begun a review of buildings and properties for finding possible reuse or repurpose opportunities. Building Utilization Review and Repurposing or BURR will focus on identifying sites in three major categories: housing for veterans who are homeless or at risk for being homeless; senior veterans capable of independent living; and veterans who require assisted- living and supportive services. The three phases planned include identifying campuses with buildings and land that are either vacant or underutilized; site visits to match the supply of building and land with the demand for services and availability of financing; and lastly, identifying campuses using VA's enhanced- use leasing authority. Under the BURR initiative, if no repurposing is identified, VA will begin to assess its vacant capital inventory by demolishing or disposing of buildings that are unsuitable for reuse or beyond their usefulness. The IBVSOs have stated that VA must continue to develop these plans, working in concert with architectural master plans, community stakeholders and clearly identifying the long-range vision for all such sites.

Program for Architectural Master Plans:

A facility master plan is a comprehensive tool to examine and project potential new patient care programs and how they might affect the existing health-care facility design. It also provides insight with respect to growth needs, current space deficiencies, and other facility needs for existing programs and how they might be accommodated in the future with redesign, expansion, or contraction.

In many past cases VA has planned construction in a reactive manner. Projects are first funded and then placed in the facility in the most expedient manner, often not considering other future

projects and facility needs. This often results in short-sighted construction that restricts rather than expands options for the future.

The IBVSOs believe that each VA medical center should develop a comprehensive facility master plan to serve as a blueprint for development, construction, and future growth of the facility; $15 million should
be budgeted for this purpose. We believe that each VA medical center should develop a comprehensive facility master plan to serve as a blueprint for development, construction, and future growth of the facility.

VA has undertaken master planning for several VA facilities, and we applaud this effort. But VA must ensure that all VA facilities develop master plan strategies to validate strategic planning decisions, prepare accurate budgets, and implement efficient construction that minimizes wasted expenses and disruption to patient care.

Preservation of VA's Historic Structures:

The Department of Veterans Affairs has an extensive inventory of historic structures that highlight America's long tradition of providing care to veterans. These buildings and facilities enhance our understanding of the lives of those who have worn the uniform, of those who cared for their wounds, and of those who helped to build this great nation. Of the approximately 2,000 historic structures in the VA

historic building inventory, many are neglected and deteriorate year after year because of a lack of any funding for their upkeep. These structures should be stabilized, protected, and preserved because they are an integral part our nation's history.

The cost for saving some of these buildings is not very high considering that they represent a part of American history. Once gone, they cannot be recaptured. For example, the Greek Revival Mansion at the VA Medical Center in Perry Point, Maryland, built in the 1750s can be restored and used as a facility or network training space for about $1.2 million. The Milwaukee Ward Memorial Theater, built in 1881, could be restored as a multipurpose facility at a cost of $6 million. These expenditures would be much less than the cost of new facilities and would preserve history simultaneously.

The IBVSOs encourage VA to use the tenants of Public Law I 08-422, the "Veterans Health Programs Improvement Act," in improving the plight of VA's historic properties. This act authorizes historic preservation as one of the uses of the proceeds of the capital assets fund resulting from the sale or leases of other unneeded VA properties.

Madam Chairman, this concludes my testimony and I look forward to any questions you and the Committee may have.