

# CARE WHERE IT COUNTS: ASSESSING VA'S CAPITAL ASSET NEEDS

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## HEARING

BEFORE THE

### COMMITTEE ON VETERANS' AFFAIRS

### U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED FIFTEENTH CONGRESS

FIRST SESSION

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## **CARE WHERE IT COUNTS: ASSESSING VA'S CAPITAL ASSET NEEDS**

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**Wednesday, July 12, 2017**

COMMITTEE ON VETERANS' AFFAIRS,  
U. S. HOUSE OF REPRESENTATIVES,  
*Washington, D.C.*

The Committee met, pursuant to notice, at 10:00 a.m., in Room 334, Cannon House Office Building, Hon. David P. Roe [Chairman of the Committee] presiding.

Present: Representatives Roe, Coffman, Wenstrup, Poliquin, Higgins, Bergman, Banks, Gonzalez-Colon, Walz, Takano, Brownley, Kuster, O'Rourke, Rice, and Correa.

### **OPENING STATEMENT OF DAVID P. ROE, CHAIRMAN**

The CHAIRMAN. Good morning, and the Committee will come to order. Welcome and thank you all for joining us at today's hearing entitled, Care where it Counts: Assessing the Department of Veterans Affairs' Capital Asset Needs.

Though this morning's hearing is ostensibly about VA's management of its extensive capital asset portfolio, it is actually about something else altogether: patient care. VA is one of the Federal government's largest property holding entities with a capital asset portfolio that includes thousands of medical facilities spanning hundreds of millions of square feet in both owned and leased space across the country. Managing and maintaining those properties and aligning them to meet the ever changing shifts in patient population and in healthcare demand and delivery is increasingly complex and costly. And I might add that the private sector is doing the same thing with bricks and mortar because of how medicine's practice today is changing.

The average VA medical facility building is five times older than the average building in a not for profit hospital system in this country and was designed and built to meet very different healthcare needs and delivery models than we see today. The consequences of this have been well documented in recent years by entities including the independent assessment, the Commission on Care, and the Government Accountability Office. All too often current facilities, including those that have been well maintained, are not equipped to support the provisions of modern high quality care and are not well suited to providing care in the current VA healthcare system. VA does not consistently allocated capital to projects that address the greatest areas of veteran needs in the most cost effective and timely manner. There is a wide and growing gap between VA's capital need and the antiquated and anticipated

resources. And previous efforts to align and realign VA capital assets have failed.

What is more, due to shifts in the veteran population VA spends millions of dollars, taxpayer dollars, every year maintaining buildings that are empty or largely so. That led the Commission on Care to include this startling statement in their final report last year, and I quote, "VHA's principal mission is to provide healthcare to veterans, yet over time has acquire an ancillary mission, caretaker of an extensive portfolio of vacant buildings." That is an extraordinary statement. VA's primary mission is caring for veterans and it is those veterans, those veteran patients, who bear the brunt of the consequences of VA's lack of physical infrastructure.

We can no longer continue to allow VA's outdated, inflexible, and ill-suited capital asset program to compromise the department's core mission and the care provided to millions of our veterans. That is why I am calling this morning a top to bottom review of all VA Health Administration capital assets. This is not something for the VA or her champions to fear. As one of our witnesses, former VA Secretary Anthony Principi will testify this morning, quotes, "VA will fail to honor our Nation's commitment to its veterans if VA's medical systems do not evolve with the times."

Rather than continuing to invest valuable resources on infrastructure in many cases long past its prime, we need to take an objective view of all VA medical facilities and smartly plan for where and how we can divest of buildings and property that are no longer needed, and more importantly for where and how we can grow to ensure that VA medical facilities maintain strong assets in communities across the country and are equipped to provide the care and services veterans need.

As the veteran population continues to shift, care continues to evolve. VA's infrastructure continues to age and veteran demand for care in the community continues to grow. A capital asset review and realignment free of political influence is critical to ensuring that the VA healthcare system remains strong and sustainable for veterans today and tomorrow.

I will now yield to Ranking Member Walz for any opening statements that he may have.

#### **OPENING STATEMENT OF TIMOTHY J. WALZ, RANKING MEMBER**

Mr. WALZ. Well I thank the Chairman, and I want to thank our distinguished panel. And Secretary Principi, it is great to have you back and I think it is worth noting there is probably no one else in America knows the very issue we are going to talk about today more than you. And we are grateful you would find the time to come and help us with this.

I would also like to thank the Chairman. I know it goes against my Minnesota Lutheran roots to, if you do a good deed and talk about it, it does not count, is the way we see these things. But I am going to talk about it. I think it has become obvious in the short time of this new Congress that this Committee is committed to tackling the big issues, to finding bipartisan issues, and to getting them done. And I am certainly glad that this is one the Chairman decided to take on also. It is important.

It is a complex and vast issue plaguing VA's ability to effectively manage its incredibly large capital asset portfolio are daunting. I do think it is worth noting the numbers even for those of us up here. VA owns over 6,000 buildings encompassing over 151 million square feet. If we were as a Committee to go visit each one of these buildings and spend an hour getting there and going between each one and we did that eight hours a day, seven days a week, 365 days of the year, we would finish in three years getting through them. This is a massive undertaking and it is one that we need to get our minds wrapped around.

VA and Congress has been very aware of this issue since the late 1990s when the CARES Commission was established under the direction of Secretary Principi. However, GAO's recent report shows little progress has been made in improving the capital management. The effective management of VA's vast and aging capital asset portfolio is intimidating, yet it is incredibly important and one I hope that we are willing to get done.

Recently GAO has found that VA has neither the process nor the data necessary to make a long term decision regarding the alignment of its facilities to the needs of veterans. Today GAO is going to testify that both the VAIP and the SCIP are ineffective and significantly flawed. The VAIP process is meant to determine veteran needs, simply put, while the SCIP process is meant to produce a long term plan to align VA capital assets with that need. These processes are absolutely crucial to VA's ability to strategically determine gaps in VA capacity to meet veterans' need and then to produce a long term plan to cover the gaps. But buildings do not deliver care and benefits. VA staff inside those buildings do. However, VA is unable to determine the amount of care its staff yields or has the potential to yield. Therefore, VA is unable to ensure existing structures are fully utilized by a highly productive staff and how that translates into veterans' care. In an age of billion dollar medical facilities, this determination is absolutely imperative and it is unacceptable we do not have it.

Tomorrow GAO is going to testify in front of the Health Subcommittee that VHA also lacks the ability to accurately determine the level of clinical productivity and efficiency of its healthcare providers. How can VA determine a building is necessary to meet a veteran's need when VA at this time cannot determine how much need is being met using the existing building? Complex problems demand complex solutions.

The failure of the CARES Commission to execute its recommendation proves that a commission is not enough. The cost of VA capital asset maintenance proves time is not on our side. I hope we, along with VA, are able to thoroughly consider pragmatic and timely solutions to the many costly issues impacting VA's ability to manage its care. And as the Secretary said, this is going to take courage. It is going to transcend politics. If it is not done now, we can no longer kick this can down the road. Because if we do, the ability to deliver that care and the capacity to deliver that care will be diminished. And all of us here have a commitment to making sure that does not happen.

So Mr. Chairman, I once again thank you for tackling the tough problems and I look forward to hearing from our witnesses.

The CHAIRMAN. Thank you, Mr. Walz. And joining us on our first and only panel this morning is the Honorable Anthony Principi, former Secretary of the U.S. Department of Veterans Affairs. And welcome, Mr. Secretary. Mr. Roscoe Butler has been here many times, the Deputy Director of Healthcare for the Veterans Affairs and Rehabilitation Division of the American Legion. Thank you for being here. Debra Draper, the Director of the Health Care Team for the Government Accountability Office. Again, many times here. And Jim Sullivan, the Executive Director of the Office of Asset Enterprise Management for the Department of Veterans Affairs, who is accompanied by Dr. Regan Crump, the Assistant Deputy Under Secretary for Health Policy and Planning at the Veterans Administration, and welcome. Thank you all for being here. And Secretary Principi, we will begin with you and you are now recognized for five minutes.

#### **STATEMENT OF ANTHONY PRINCIPI**

Mr. PRINCIPI. Thank you, Mr. Chairman and Ranking Member Walz, Members of the Committee, it is certainly an honor to be back before you this morning. And I just commend you for the working relationship that all Members have. And veterans should be reassured that you are tackling the tough issues. So thank you very, very much.

Medical care is a key component of the benefits and services enacted by Congress in recognition of the sacrifices of the men and women whose service in uniform preserved and protected our Nation's freedoms. Neither medical science nor the veteran population is static and unchanging and VA must always provide veterans with modern, high tech facilities to offer them high quality healthcare. The department will fail to honor our Nation's commitment to its veterans if VA's medical system does not evolve with the times.

VA is a proud organization with a great history. The department has made enormous contributions to American healthcare across the spectrum of care, research, rehabilitation, and has been a life-line for tens of millions of veterans returning to our shores. But many VA medical centers were designed and built in an era in which medical care was synonymous with hospital care and long term psychiatric care, facilities built in the twenties and thirties, 1,700 beds, still in existence today, with an average daily census of maybe 166 patients. American medicine and VA healthcare has transformed itself from hospital centered to patient centered treatment. Most veterans, like most Americans, see their physicians on an outpatient basis and much treatment is provided by prescription drugs.

However, while the practice of VA medicine has evolved, VA medical infrastructure has not kept pace. VA facilities are out of step with changes in the practice of medicine and with the statutory changes in VA's healthcare benefits package. In addition millions of veterans following the population migration patterns of the Nation have moved to different parts of the country. And as GAO noted in its recent report on VA real property, the new Choice program has also reduced the need for some VA facilities and services VA offers. If VA does not realign itself, the current decline in the



veteran population will make many VA medical centers museums of the past, not the guideposts for the future they should be to care for our Nation's veterans.

When I became Secretary in 2001, President George Bush reminded me that every dollar my agency spends is a dollar taken out of someone else's hard-earned pay. It is not how much money you are given in your budget, he told me that is important. He said it is whether you spend the money wisely. We are stewards of the public trust, he reminded me, and we must never forget that. I had an opportunity to recall his words a short time later when I was stuck in traffic in New York City. As my car idled in front of VA's Manhattan Hospital, I looked up at the hospital's enormous bed tower. Among the hundreds of windows looking out on First Avenue, only a handful were lit. I did not know what to make of it.

I learned a short time later when I returned to Washington that the hospital was one of many built in the 1940s and fifties to handle the influx of ill and injured World War II and Korean War veterans. It once held 800 veterans, as did nearby hospitals in the Bronx and Brooklyn. I was told that the three hospitals that night were caring for only 283 veteran patients altogether. All the other beds were empty and there were tens of thousands of empty beds throughout VA's system.

Accordingly I commissioned a comprehensive assessment of VA's capital infrastructure and the demand for VA healthcare. The process was called Capital Asset Realignment for Enhanced Services, CARES, and was modeled on DoD's infrastructure review process. The CARES Commission offered sound recommendations for realignment and reallocation of the department's capital assets to meet demand of VA's services over the next 20 years.

Unfortunately the CARES and DoD processes differed in one way. Under CARES there was no requirement for Congress to adopt or reject the commission's final recommendations as a package. As a result, recommendations for some needed new hospitals and outpatient clinics were accepted. Most of those to change, realign, or maybe close the mission of other facilities were rejected.

I know that the difficulties of agreeing to such a procedure for Members of Congress cannot be overstated. Having served as the Chairman of the 2005 Defense Base Closure and Realignment Commission, BRAC, I know firsthand from visiting many of the military installations slated for closure or realignment now trying this process can be for you and your states. The closure and realignment are easy to write on paper but they have profound effects on communities and the people who bring those communities to life. But VA is simply spending too much money on bricks and mortar rather than doctors and nurses.

VA's current budget request is \$186.5 billion. In my last year as Secretary, in 2005, that figure was \$69.4 billion, a 268 percent increase. We are doing a disservice to the veterans VA is charged to serve and to the American people if those resources are not used wisely and well. Our Nation simply cannot afford to maintain a vast infrastructure built for a different time and healthcare delivery that was to care for tens of millions of veterans as they returned from World War II, Korea, and Vietnam, and even from earlier conflicts.

One other area in which there is an opportunity for both enhancing and using taxpayer dollars more wisely is for VA and DoD to more widely share facilities and services at local levels. There are many DoD hospitals that have very low inpatient census as well. This is one of the CARES Commission's recommendations and more can be done in this area.

A full review of VA's infrastructure, Members of the Committee, is the right thing to do. A review that is open, transparent, and apolitical. Those impacted by the decisions deserve no less. Thank you very much.

[THE PREPARED STATEMENT OF ANTHONY PRINCIPI APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Mr. Secretary. Mr. Butler, you are recognized for five minutes.

#### **STATEMENT OF ROSCOE G. BUTLER**

Mr. BUTLER. Thank you, Mr. Chairman. Each year since 2003 the American Legion System Worth Saving Program has conducted site visits to VA healthcare facilities across the country. One thing we find in common is that VA has enormous amounts of aging buildings that are either underutilized or vacant. VA has a large inventory of buildings that are over a half century old, resulting in significant costs for upgrades and needed replacements of many parts of the facilities' aging infrastructures.

As I mention in my written statement, GAO has been reporting on this issue dating back to 1991, or probably even earlier. GAO published a report title, VA Struggling to Respond to Asset Realignment Challenges. It has been 26 years since the 1991 GAO report was issued and we are here again today to have an open and candid discussion on how to address VA's capital asset needs.

Good morning, Chairman Roe, Ranking Member Walz, and Members of the Committee. On behalf of our National Commander Charles E. Schmidt, and the over three million voting members of our largest wartime veterans service organization, we want to say thank you for conducting this hearing that addresses VA's capital asset needs.

Today the Veterans Health Administration is the largest integrated healthcare system in the United States, providing care at over 1,233 healthcare facilities, including 168 medical centers, and 1,065 outpatient sites of care of varying complexities serving more than 8.9 million veterans. In spite of the exceptional healthcare VA provides, its aging infrastructure with a number of buildings being underutilized or vacant, creates problems for VA to maximize the use of its capital assets.

According to information provided by VA in fiscal year 2016, VA had 403 vacant buildings at an annual operating cost of \$6,674,227 and 784 underutilized buildings at an annual operating cost of \$20,266,271. VA defines an underutilized building as an individual building that is occupied and in use, but the functions housed there do not require the full amount of space in the building to operate.

If there was unlimited funding the easy answer would be to dispose of all of VA's vacant buildings and build new modern facilities. But the reality is that funding is not unlimited and there are no

easy answers to these questions. Which is why everyone is here today to have an open and candid discussion to address VA's aging capital asset portfolio.

In 2016 the American Legion renewed Resolution 136, Strategic Capital Investment Planning Program, which urges Congress to provide increased appropriations annually to address Department of Veterans Affairs construction deficiencies and gaps identified by VA's strategic capital investment planning program. VA includes activation costs in their future SCIP cost projections and allocations so that VA's budget will not have to offset this lack of funding and VA continues to be transparent about SCIP's progress by publicly posting information about projects and costs on an annual basis.

Based on the American Legion's review, addressing VA's capital asset need is not a new phenomenon. There have been numerous government reports over the last 26 years addressing the same topics. However, countries around the world have placed high value in their historic properties, such as historic capitals, and the United States visitors frequently visit Washington's monuments and the Lincoln Memorial for its historic contributions to this Nation's historic value. In the past, our System Worth Saving team has visited the Hot Springs, South Dakota medical facility, which was designated as a historic national property. Subsequently, VA was pursuing to close that facility until Dr. Shulkin overturned the former administration's decision. The American Legion calls on Congress and VA to place high value on VA's historic national properties.

The American Legion is concerned that VA has not routinely, actively engaged veterans service organizations in the discussion about their plans to address VA's capital asset needs. VA must do better involving VSOs in these discussions.

Twenty-six years later, we are still trying to find solutions to VA's capital asset needs. The American Legion hopes it does not take another 26 years to find solutions to VA's capital asset needs.

The American Legion thanks this Committee for this opportunity to explain the position of the over three million voting members of the American Legion. Thank you.

[THE PREPARED STATEMENT OF ROSCOE G. BUTLER APPEARS IN THE APPENDIX]

The CHAIRMAN. Mr. Butler, thank you. And full disclosure, I just mailed my 2018 dues in before I came back.

Mr. BUTLER. Thank you, sir.

The CHAIRMAN. Ms. Draper, you are recognized for five minutes.

#### **STATEMENT OF DEBRA DRAPER**

Ms. DRAPER. Chairman Roe, Ranking Member Walz, and Members of the Committee, thank you for the opportunity to be here today to discuss VA's capital asset program, including our recently issued report that examined VA's efforts to align its medical facilities with veterans' needs.

VA is one of the largest property holding agencies in the Federal government. In 2014 VA reported that its inventory included more than 6,000 owned and 1,500 leased buildings, together covering approximately 170 million square feet of space. Many of these facili-

ties are underutilized and outdated, creating a variety of challenges for alignment.

As we discussed in our recent report, there are a number of factors that affect the department's alignment efforts. First, VA projects a 14 percent decrease in the veteran population by 2024. And as the map on the screen shows, up on the board, it also expects a continued migration of veterans from the Northeast and Midwest areas of the country to areas in the South and West, a trend that also mirrors that of the general population.

Second, similar to trends in the healthcare industry overall, VA's model of care continues to shift away from inpatient to outpatient settings of care, the latter of which VA generally houses in converted inpatient space or in a growing number of outpatient clinics. The photo is of a closed inpatient wing at the Brooklyn facility.

Third, although VA has traditionally provided care primarily through its own facilities, it is increasingly relying on care provided in the community.

Fourth, an aging infrastructure affects facility alignment because many VA facilities are not well suited to provide care in the current environment, as the photo of an outdated double occupancy room at the Manhattan facility shows. The average age of a VA medical facility is 60 years, which is five times older than that of an average not for profit hospital building.

Facility planning officials told us that it is often too difficult and costly to modernize, renovate, and retrofit older facilities. Photos from the Waco facility illustrate these challenges.

And finally, the historic status of some VA properties adds to the complexity of alignment. VA has approximately 3,000 historic buildings, structures, and land parcels, the third most in the Federal government. In some instances renovations may be more expensive but demolition and rebuilding may not be an option given the historic designation. These photos of buildings, of structures designated as historic from the Kerrville, Chillicothe, and Waco facilities provide good examples.

VA has recognized the need to improve planning and budgeting for modernizing its aging infrastructure and aligning its facilities with veterans' needs. A previous effort at doing this, known as CARES, was never fully implemented and was halted about eight years ago. VA has more current efforts to align its facilities with veterans' needs, including the SCIP process and the integrating planning process. However, both of these have limitations.

VA relies on the SCIP process to plan and prioritize its capital projects. But limitations, such as subjective narratives, long timeframes, and restricted access to information underlie VA's ability to achieve its goals. For example, the time between when facility planning officials begin developing the SCIP narratives and when they are notified that a project is funded has taken between 17 and 23 months over the past six fiscal years' SCIP submissions. While some of the budget timing is outside of VA's control, delays in reporting of the SCIP results has made it difficult for local officials to understand the likelihood that their projects would be funded.

The integrated planning process also has limitations. Among other goals, it is intended to produce facility master plans for every VA medical center at a total cost of more than \$100 million when

complete. A significant limitation to this process is that it assumes that all future growth in services will be provided directly through VA facilities, an inaccurate assumption given the increasing role of care in the community. Some local VA officials told us that they bypass the integrated planning process and instead contract for their own facility master plans.

Additionally, VA has faced stakeholder challenges to its facility alignment actions, including from veterans, state, local, and Federal officials, employees, historic preservation groups, and others. We found that VA has not consistently followed best practices for effectively engaging stakeholders in these decisions or evaluated the effectiveness of their stakeholder communication strategies.

In conclusion we have made several recommendations that if implemented could improve VA's ability to plan for and facilitate its alignment efforts. Specifically we recommended that VA improve the SCIP process; discontinue or improve the utility of the integrated planning process; and improve communications with stakeholders.

Mr. Chairman, this concludes my opening remarks. I am happy to answer any questions.

[THE PREPARED STATEMENT OF DEBRA DRAPER APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Ms. Draper. Thanks very much. And Mr. Sullivan, you are now recognized for five minutes.

#### STATEMENT OF JAMES M. SULLIVAN

Mr. SULLIVAN. Good morning, Chairman Roe, Ranking Member Walz, and Members of the Committee. I am joined by my colleague, Dr. Regan Crump, and we are here today to discuss VA's capital asset needs, and we acknowledge the many challenges that face us as we attempt to modernize the VA healthcare system.

VA's mission is distinct compared to other agencies. We operate the largest integrated healthcare system in the Nation, with 135 national cemeteries, 1,700 hospitals, clinics, and facilities used to provide benefits and services to our veterans. Our portfolio consists of approximately 180 million square feet, 86 percent of which is owned, and in many cases the average age of a facility exceeds 60 years.

Most of our infrastructure is in need of repair and replacement and requires considerable investment. VA has more than \$50 billion in capital needs to upgrade existing facilities or replace existing facilities to meet modern healthcare standards.

Secretary Shulkin has made it one of his top five priorities to modernize the VA system. We are supporting his priority by getting rid of buildings that are no longer needed to provide services to veterans. We have identified 430 individual vacant buildings, totaling six million square feet across the country. It costs VA an average of \$7 million a year to operate these buildings and we want to redirect these resources to services.

We are initializing disposal and reuse actions for these 430 vacant buildings over the next two years. VA will begin performing due diligence, ensuring compliance with applicable laws and regulations, and initiate disposal or reuse transactions. In the last 30

days alone, we commenced the process for 71 vacant buildings through an enhanced use lease for repurposing buildings at Perry Point, Maryland, 54 buildings, and we completed the excessing process to GSA of the hospital in Pittsburgh, Pennsylvania, which was 17 buildings.

While we are working with an aggressive timeline to address our vacant buildings, we anticipate hurdles that may slow us down. Some challenges that can impact our timeline include the lengthy processes associated with the National Historic Preservation Act, the National Environmental Policy Act, and the location and condition of buildings, and local and national stakeholder concerns. VA welcomes any support from Congress to streamline these processes so that we can more efficiently and effectively manage our assets.

While challenges do exist, and there are many, we have made some progress in reducing unneeded buildings. Since 2004 we have disposed or reused over 1,000 buildings, totaling approximately eight million square feet and about 1,000 acres. One of the most successful tools we have experienced using is our enhanced use lease authority. EUL allows VA to out-lease assets to private and public sector entities for repurposing. Currently we can out-lease vacant buildings and excess land in return for supportive housing for homeless veterans and their families. This program has provided significant benefits to VA in terms of cost savings, improved facilities, and increased services to our veterans.

To date over four million square feet has been out-leased through EUL and we have in place 2,700 operational housing units across the country. VA previously had a broader EUL authority but that expired in 2011, and our 2018 budget includes legislation requesting the reintroduction of a broader scoped EUL.

VA needs your help and welcomes any new or expanded tools to address our most challenging issues that we have. Our 2018 budget includes proposed legislation to increase VA's flexibility to meet some of these needs. The budget includes proposals, one, to increase the threshold for the minor construction program to \$20 million; eliminate statutory impediments acquiring joint VA facilities, much as Secretary Principi mentioned in his testimony; expanded EUL authority; and providing for the authorization of 28 major medical leases to serve the outpatient needs of our veterans. In terms of addressing recommendations of the independent assessment, the Commission on Care, and GAO, VA agrees with the majority of these recommendations and recognizes we need to do better. We are working towards that goal of a high performing healthcare network that takes into account current and future veteran demand. VA partnered with private sector experts to conduct objective assessments and develop local healthcare modernization optimization plans. The primary outcomes of this assessment will be plans for each market across the country to develop a high performing healthcare network which will then feed into VA's capital planning process, SCIP. Once the market assessments are complete, recommendations may include needed capital investments, divestitures, partnerships, and other approaches to modernize VA's infrastructure. These investments then will be prioritized and included in future budget requests. VA expects the market area opti-

mization plans will address many of the issues raised by GAO, the commission, and the independent assessment.

Mr. Chairman, Ranking Member, and Members of this Committee, this concludes my statement. We welcome any suggestion and as we confront this major challenge facing the VA. I am happy to respond to any of your questions.

[THE PREPARED STATEMENT OF JAMES M. SULLIVAN APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Mr. Sullivan. And I thank all of the members of the group that is here today. And I want to start by just saying a couple of things.

One, this is very hard. And this is not glitzy stuff but this has got to be done. And I appreciate what each one of you bring to the table. And as I said in my opening remarks, that the private sector is undergoing exactly the same thing. The hospital that my two children were born in in Memphis was at the time the largest private hospital in the world, 2,000 beds, Baptist Memorial Hospital. That hospital is gone. It has been dropped. And they have now downsized to a more efficient, you know, 21st Century model where care can be given. And there were just hundreds and hundreds of empty beds in that hospital. And they realized years ago they had to change their model. And I think the VA is undergoing exactly the same thing as the private sector is doing now.

And Mr. Butler, you brought up some great points about the historic buildings. And I think we need to look at public-private partnerships, what we can do with these. We have one in my local VA at home that is a medical, basically a museum that could be used. But if you engage the private sector and let them maintain the building, there are a lot of options out there that we could do to maintain these historic buildings and have them used for other purposes. And certainly not just bulldoze them. I think there are many communities that would love to do that and share that rich culture in their community.

I think Walter Reed is an example. We realized that fixing Walter Reed just was not, I mean, as much as I loved going over there, it was just too much of an investment for modern healthcare. So we moved it out to Bethesda and to a more modern facility. So I think the DoD has done some of that and I think VA is going to do that.

And let me just ask, any of you can answer that, how can you elaborate on how patient care is impacted by aging infrastructure? And would it be fair to say that access to care is in some cases negatively impacted by the limitations of an aging VA medical facility? And any one of you can take that question.

Mr. PRINCIPI. I will start, Mr. Chairman. I certainly think that is the case. If you are devoting scarce resources to bricks and mortar, you are taking care away from veterans. And I think first and foremost we have to provide high quality care to veterans, whether it be in a high tech inpatient facility, outpatient clinic, or the community. Public-private partnership, as this Committee has advocated. So I think there is an impact on quality of care. And unless changes are made I think it will continue to do so.

The CHAIRMAN. Mr. Butler? Yes, sir?

Mr. BUTLER. Hot Springs, South Dakota is a prime example, where that facility is a national historic designated facility. And it was a facility that was designated to be closed. The community was in uproar because of that decision. It would place veteran having to drive much further to other facilities to obtain their care because care in the local community was not available for them. And so I think you have to look at everything in totality to make sure that when you make those decisions, you are taking everything that needs to be considered in play to make sure that the veterans' care, they can receive the best care. Regardless of it is in a VA facility or it is outside the VA facility. But you have to ensure that if you are closing, if the recommendation is to close a facility, that the veteran can obtain that quality care elsewhere that is convenient for the veteran and does not cause hardship to the veteran.

The CHAIRMAN. I could not agree more. I think if you are doing that, you should be able to show that actually that quality of the care will go up, not lose quality. I could not agree more with that.

Mr. Sullivan, how much total resources are spent maintaining space that is either vacant or largely vacant across the entire, you may not know this, across the entire VA system?

Mr. SULLIVAN. The cost we are spending is about \$7 million annually. If we include what is underutilized as well, it comes to about \$29 million.

The CHAIRMAN. And so that is a building that is there, that is very underutilized or—

Mr. SULLIVAN. It is a building, if you look at the example, if you had a clinic that had 100,000 square feet and your real requirement based upon veteran need is 10,000 square feet, but you are using 100,000 to serve them, then that is what an underutilized facility would be.

The CHAIRMAN. They did not start the clock on me until some time, so I think I have run out of time. I am not sure. So I am going to yield to Mr. Walz.

Mr. WALZ. He is kind, I agree. So well thank you all. And great testimony, and I think teeing up where we are at. So I am going to cut right to the chase, Mr. Secretary, with you is in your opinion, I think we all probably know the answer but it is important I think to hear it in this setting, what was the biggest barrier towards the implementation of the full CARES Commission? And how would you suggest we do not make that same mistake?

Mr. PRINCIPI. Well I think the clearest limitation, and I might add I was very proud of the CARES process. I think the team did an extraordinary job. It was data driven. It was based on sound information. And very importantly, I insisted that there be listening sessions. That they travel around the country and talk to the communities, talk to labor, talk to management, and really get their insight because it is a difficult process. But the clearest, and the veterans organizations were fully behind the CARES process and they stood with me when the decisions were made. But obviously unlike the DoD process, when you do not have some teeth behind it, it will fail. The pluses were good but those that wanted to realign or close a facility became difficult because of the political process, which I enormously respect. It becomes very, very difficult. And I tried to point that out in my testimony.



So I think that this Committee, I urge this Committee to create a commission. Allow the Secretary, who I think is doing a great job, allow him to come up with the recommendations, submit them to a bipartisan commission, and give the commission some teeth based on their decisions. Submit the plan to Congress and let the Congress vote on the plan up or down, rather than singling out individual facilities.

Mr. WALZ. No, I appreciate that. Mr. Butler, I am, up here I was just showing the photo around. I am very familiar with Hot Springs. I lived in Chadron, Nebraska and then in Pine Ridge for a while. I think people need to know that facility is drawing from South Dakota, Nebraska, and Wyoming and it is pretty open out there. And that is probably one of the most beautiful VA buildings. The administration building is gorgeous. So I think trying to balance these things about how do we save some of these assets in terms of their historic value but that one always comes up with me because of the massive number of beds. And I think that one might be utilized three beds a night because of this change. So I am very cognizant of that.

I want to come back to the process, and maybe this is for Ms. Draper, and to you, Mr. Sullivan, about what we are trying to get to. And Ms. Draper, first of all, based on what you know, are either the VAIP or the SCIP processes truly reflective of veteran need, VA resources, and stakeholder concerns when managing capital assets? Is this the best practice way to do this?

Ms. DRAPER. Well we have found limitations with both, as I talked about. But one of the issues with the SCIP process, it is supposed to be a ten-year planning process but the emphasis is really on the first year. So what local facilities told us is they often to address gaps identified through the SCIP process, they often put projects in out years that they never intend to actually undertake. So really the focus is on the first year. It is not a long term planning process, as we found and we talked about in our report.

There are also many limitations with the integrated planning process. One is that it does not account for the care in the community, which is a major assumption that should be considered because you do not want to simultaneously develop new capacity while you are also getting it delivered in the community. But it also has other limitations. For example, the costs do not include all the life cycle costs of a project. So there are operating costs that are not included that, you know, which OMB recommends they be included. There is a lack of standardization in the facility master plans. So they have different contractors doing the master plans. And so there is a lot of variation. So it is really difficult to determine how comparable they are. And then the other thing, and I think we have talked about this, is accountability. So there are recommendations that come out of the integrated planning process but there are no requirements for those to be implemented.

Mr. WALZ. That is the question, and I think, ma'am, I am going to leave it to my colleagues. They will have questions to ask because obviously in this, and I am sure Mr. Coffman will bring up, in this planning process was certainly the Denver VA facility. And this year I am wondering how does all this fit together? When we see the VA's budget request a cut to construction by 4.3 percent,

was that budget crafted by looking at these things, putting it together, deciding how we are going to dispose of these buildings? How we are going to repurpose? And what we need to do to build? I just wonder, and I know it is out there and I do not want to be that person who drives by a construction project and thinks, I know better than how it is done, or why it was decided to do that, but I as a Member of this Committee am having a hard time understanding how we are making those decisions. So I want to just leave that lay out there. That I think we need to know how did we come up with our budgeting number? How do we know what we really need? Because I am still not convinced we know how to utilize that. And I yield back.

The CHAIRMAN. I thank the gentleman for yielding. Dr. Wenstrup, you are up.

Mr. WENSTRUP. Thank you, Mr. Chairman. Thank you all for being here today. And I think it is important to note that this Committee is dedicated to the care of our veterans as well as respecting the history of the VA and this Nation. So as we move forward, we are going to be facing challenges.

One of the things I have harped on since I have been here is really knowing how productive we are when it comes to patient care. And I have always talked about relative value units, RVUs, and using that as one standard of measure. So Mr. Sullivan or Dr. Crump, maybe you can answer for everyone, how exactly doctors that are providing for our veterans in the Choice program, how are they paid?

Mr. CRUMP. Today in the Choice program doctors are paid based on a fee basis. And so we are using the Medicare rates for—

Mr. WENSTRUP. Which is RVUs, correct? Relative value units?

Mr. CRUMP. Well some of the basis of the fees is RVUs.

Mr. WENSTRUP. Right.

Mr. CRUMP. But it is a fee basis.

Mr. WENSTRUP. Okay. So we are tracking that. We know how we are paying them and what they are producing. So do we track RVUs for all of our producers across the entire VA? Do we know what they are producing? And I am going back to something I think GAO did a couple of years that ended up evaluating what it cost in certain facilities for a primary care visit. And it came down to when you add up all the expenses of the facility, etcetera, that it was really around \$400 to \$600 per office visit in certain locations. So I think it is important that we are tracking productivity as we do this review. So are we able at this time to track RVUs of every provider in the VA?

Mr. CRUMP. What we are doing right now is changing some of our methodologies for tracking productivity and we are incorporating the use of RVUs on a national basis.

Mr. WENSTRUP. But so far that has not been done as like a requirement?

Mr. CRUMP. It has been done to some extent.

Mr. WENSTRUP. Because I think, to some extent, I think that is really something we have to look at when we are looking at our assets, is how much is actually being produced in a certain facility. Maybe it is a physical limitation, or maybe we are just spending way too much. It is I think an important tool as we are taking on

this challenge to understand what is going on. Because for example, if I was paid \$100 per RVU to pay all of my bills in a private practice, I could not sustain that very long. And so I think that we have to look at that and say, you know, look at our productivity per cost. And the other question I have is are there incentives right now in the VA management to reduce costs or increase productivity? In other words, reduce costs without reducing productivity? Or to increase productivity in some way that we are getting more bang for our buck? Are there incentives for that in our management?

Mr. CRUMP. Dr. Wenstrup, there are provider incentives for productivity. And we are also in the process of one of the largest modernizations of VA healthcare in history. And so improving employee performance and productivity is a part of that process.

Mr. WENSTRUP. But can you take a second to describe what that incentive is for a provider?

Mr. CRUMP. I do not think I would be able to describe the exact specification of that methodology today. But we can get back to you on it.

Mr. WENSTRUP. And does it vary? Or is it across the board, do you know?

Mr. CRUMP. It is across the board.

Mr. WENSTRUP. Okay. Well thank you. Because I think this is going to be an important thing going forward. And if it takes us mandating that this be one of the tools that we have as we evaluate our assets, then I think that we should do that right here and put that into legislation where we understand what we are actually producing. And then hopefully at a local level you will have people be able to make some decisions that make sense, where you are actually looking at what you are getting. What is your bang for the dollar, bang for the buck that we are getting?

So with that, I want to yield back. But I thank you for that input. And I do not know if you have anything to add to that, Ms. Draper?

Ms. DRAPER. I do not. I know that they are working on, you talked about productivity, but they do not measure RVUs for every specialty that way. So I think they are in the process of looking at that, as Dr. Crump talked about.

Mr. WENSTRUP. Thank you. And I yield back.

The CHAIRMAN. I thank the gentleman for yielding. Mr. Takano, you are recognized for five minutes.

Mr. TAKANO. Thank you, Mr. Chairman. Mr. Sullivan, of the 430 buildings that the VA has designated as vacant, how many provide some type of direct care to veterans?

Mr. SULLIVAN. None.

Mr. TAKANO. None? Okay. How many, how does the VA plan to ensure the veterans' ability, so really, since none of them provide direct care, we do not really have a concern about how the VHA is going to provide, the veterans, who have, so we do not have veterans that are receiving direct care—

Mr. SULLIVAN. No. A few of them have some support, some administrative support in them. That will be relocated.

Mr. TAKANO. Okay.

Mr. SULLIVAN. But there is no direct care in any of those buildings.

Mr. TAKANO. Okay. How was the VA able to determine the percentage of utilization for the 430 vacant buildings?

Mr. SULLIVAN. It was based upon the folks on the ground, in the field, identifying those buildings as vacant or having minimal use.

Mr. TAKANO. Okay. And of these buildings, so that we mentioned that we intend to either dispose or reuse, how many have been determined to be unsuitable for the provision of services to homeless veterans?

Mr. SULLIVAN. In conducting the due diligence, that is one of the items that will be looked at.

Mr. TAKANO. Okay. So it has not really been determined yet?

Mr. SULLIVAN. There has been an initial review annually to see if any of those buildings are candidates for homeless housing. And some of them, for example in Perry Point, as I mentioned earlier, 54 of those buildings are in the 430, came off because we could reach a private sector developer to handle the housing of those buildings. So there are some, but a lot of them are such condition that it really becomes cost effective—

Mr. TAKANO. So the evaluation is not really complete for all of the 430?

Mr. SULLIVAN. Correct.

Mr. TAKANO. Okay. Are there current barriers regarding the usage of an EUL to ensure the property is determined to be suitable for the purpose of providing services to homeless veterans? This question is kind of wordy. So are there barriers regarding the usage of an EUL to ensure that the property is determined to be suitable for the purpose of providing services to homeless veterans are utilized quickly and efficiently?

Mr. SULLIVAN. The only barriers are actually the financing. So from a legislative standpoint, the fix that was made to this program a couple of years eliminated most of the barriers in terms of housing. What the barrier would be is if you wanted to go to a medical EUL model, which is I think what people have talked about earlier, which really probably is the future at VA. If we can bring in private sector expertise and private financing to provide state of the art facilities, that would require a change to that program or additional authority to that program or a complementary program so that we could use that to go out and get needed medical facilities right now where we are restricted to just homeless housing or support housing.

Mr. TAKANO. So , the current statutory framework kind of constrains us to serving the homeless. But if we were to expand into a—

Mr. SULLIVAN. That is correct.

Mr. TAKANO [continued]. —partnership in the health area, this would greatly expand our ability to—

Mr. SULLIVAN. That would be one of the tools to fill the gap, especially as I believe GAO and others have testified here, we know there is not a limitless pot of money to deal with VA facilities. So we have to look at another source. And I think tapping private sector financing is the long term solution to our capital needs. And not only the capital piece of it in terms of their finance ability that they

would bring to it, but also using some of their expertise using local codes and standards, using local practices in the community, so when we came in and put a clinic in or a support facility we use those standards and those practices there. So that they would be financeable and they would also, should VA not have a use for them in the future or as time went on, they would easily be reusable by the private sector because we were using their script for doing this. And I think that is absolutely key as we go forward. And I know we are working within the administration hopefully in the President's infrastructure bill to submit that kind of a proposal to Congress.

Mr. TAKANO. Well Mr. Sullivan, with this in mind, what is the status of the public-private partnership pilot program?

Mr. SULLIVAN. Right now we do not have a true public-private partnership program. What we have is the CHIP IN Act, which is a donation program that Congress gave us which we really appreciate for five pilot sites. What we would see is a better model, or not a better model, but an additional model would be an expanded EUL or a true P3 program that would allow us to tap private sector financing and private sector expertise. And I think in this instance there is not one single tool that is going to give us this. I think we need to look at it with multiple tools, whether it is EUL, P3, other models which other folks on the Committee may have ideas on as well. I mean, we need to look at a whole suite of tools to be able to deal with this huge challenge we have.

Mr. TAKANO. Speaking to Members who have districts with some of these aging facilities, I mean, I think you are right. I think there is a lot of folks that are looking at all sorts of ways they can reuse these properties which I believe would not have to be to the detriment of providing the current healthcare needs of the veterans that are being served. I yield back, Mr. Chairman.

The CHAIRMAN. I thank the gentleman for yielding. Mr. Coffman, you are recognized for five minutes.

Mr. COFFMAN. Thank you, Mr. Chairman. And I thank you, Mr. Principi, for being here today and for your service to our country as the former Secretary of the VA. There are 430 buildings, VA buildings, vacant for the most part. Now it is my understanding that the Secretary, when you were Secretary, and the Secretary now, does not have the unilateral authority to close any of these facilities or dispose of any of these facilities, am I correct in that?

Mr. PRINCIPI. I believe he does have the authority.

Mr. COFFMAN. He does have the authority?

Mr. PRINCIPI. Yes, absolutely. And again, it could be stopped or rescinded by Congress if they elect to do so. But I believe I had the authority to close or realign VA facilities or buildings subject to certain limitations.

Mr. COFFMAN. Okay. Mr. Sullivan?

Mr. SULLIVAN. Yes. That is absolutely correct. What we are talking about here are individual buildings, and there is no prohibition on the closing of individual buildings, except complying with historic, environmental—

Mr. COFFMAN. Right.

Mr. SULLIVAN [continued]. —and other regulatory issues that do take some time. But there is no prohibition on those.

Mr. COFFMAN. But I understand closing, but disposing of?

Mr. SULLIVAN. There is no prohibition.

Mr. COFFMAN. Okay.

Mr. SULLIVAN. We will either reuse it through one of our tools or we will do a report of excess and give it to GSA as we have, for example, just on the Pittsburgh hospital.

Mr. COFFMAN. So why have you not moved on the 430 buildings that now stand vacant?

Mr. SULLIVAN. We have. In this case, we have moved on, in the last 30 days we have moved on about, I can give you the exact number, it was about 71 of them. We expect to move on an additional 71 of them within six months, and within another year about 288 additional ones. So by the end of two years we will do the entire 430 will be commenced in that process, whatever it is.

Mr. COFFMAN. And how long does that process take to go through? Or is it fairly variable—

Mr. SULLIVAN. It is really market driven—

Mr. COFFMAN. Yeah.

Mr. SULLIVAN [continued]. —based upon, if we are going to GSA to sell it, it is going to be based upon the market, what GSA can get for those buildings and how hard they find to do it. If we find a partner to reuse it, it could move pretty quickly. If it is a simple demolition, depending upon historic and environmental issues at the site, it can, you know, be anywhere from six months to 18 months depending upon that process. It is very locally driven and in each state, for example, the historic preservation entity in some states are very cooperative with VA and look to move forward. In other states it is more of a challenge and that takes more time.

Mr. COFFMAN. Does GSA, once you turn it over to GSA, do they take it from there? Or is it, do you have to, is it a cooperative—

Mr. SULLIVAN. It is cooperative but they really have the ball.

Mr. COFFMAN. Okay. Good.

Mr. SULLIVAN. They are the ones who do this all the time. They have an office set up that just does this as their single focus. And that is why we took Pittsburgh, for example, and gave it to them. We plan to have two or three other hospitals that have been vacant for a long time moving to GSA pretty quickly.

Mr. COFFMAN. Why has it taken so long to get this process started? It just seems like you have identified the 430 but then we are just, it seems like we are just starting on this process.

Mr. SULLIVAN. Well now since 2004, I think I can give you the figures—

Mr. COFFMAN. Right.

Mr. SULLIVAN [continued]. —I think we have gotten rid of eight million square feet through this process. We did not use GSA, quite honestly, until the last year or two because prior experiences with GSA were not very receptive to moving properties. But I think they have retooled and refocused so I think it is a good opportunity.

Mr. COFFMAN. Okay. What is the point of having a hotel in Paris?

Mr. SULLIVAN. VA—I think you are referring to the Pershing Hall facility?

Mr. COFFMAN. Yes.

Mr. SULLIVAN. Yes. Congress gave it to VA because at the time it had fallen dormant. There were squatters in the building. They gave it to VA after several other agencies attempted to maintain it. And we used a EUL like authority to put a hotel in place and VA receives \$300,000 to \$400,000 a year in rent from that hotel. And I know there is a proposal for folks who want to sell it. VA supports selling that. We do not have the authority to do it. And if it is, if we are given the authority, we would hope that the basis for the sale would be the market value of that asset, which we believe is somewhere between \$30 million and \$35 million, which we would hopefully in that legislation be given the authority to reinvest that money in care for veterans or in infrastructure improvements. So we were tasked by Congress to take it over and we did it. And there is no pride in ownership of that asset, I mean.

Mr. COFFMAN. Thank you. Mr. Principi—

Mr. PRINCIPI. Yes.

Mr. COFFMAN [continued]. —was that under your watch? Or was that under—

Mr. PRINCIPI. Actually, Mr. Sullivan knows it was on my watch when I was Deputy Secretary during Bush 41 and Chairman Montgomery of this Committee urged me to take possession. It was actually an American Legion, it is called Pershing Hall, it was an American Legion building. An absolutely extraordinary structure in the heart of Paris. And it was in really, as Mr. Sullivan indicated, really in a state of disrepair and magnificent artifacts were being stolen. And so I became the landlord, so to speak, and it became a hotel. And that is where it stands today.

Mr. COFFMAN. Okay. Thank you, Mr. Chairman. I yield back.

The CHAIRMAN. I thank the gentleman for yielding. Ms. Brownley, you are recognized for five minutes.

Ms. BROWNLEY. Thank you, Mr. Chairman. And I too thank the panelists for being here this morning. I wanted to direct my line of questioning around leasing and what I believe to be advantages of leasing versus building brick and mortar facilities across the country. And particularly, when you look at our community clinics across the country. I know right now today we have 30 lease authorizations for facilities for clinics across the country, but yet we do not seem to get there. And I think there is a rationale behind that. But I was just wondering, Mr. Sullivan, you know, with 30 lease authorizations out there for new facilities but not meeting that need, I mean, what do you think that delay is with regarding patient care?

Mr. SULLIVAN. Right now we have 28 leases that are, 28 that are pending authorization. And that represents about 2.2 million annual visits of care. Many of these have been submitted in the budget for the last two years. We believe that, we have not had a case where a lease has closed. But we are very fearful that about 50 percent of these are replacement leases for existing leases that are out there. And through a lot of good work and diligence by our real property people we have kept them all open. But at some point an owner of one of these leases can say, I do not want to, I do not want to stay anymore. So I mean, there is some risk there. We also, probably a bigger risk is that once we reach the end of some of these terms, we are at the mercy of the person who owns it. In

a lot of cases they have increased the rents and we have no choice but to pay it. So, I mean, it is a big issue for us in terms of creating that additional access. And we believe leasing is better, not in every case but in a lot of cases, than building and owning so that we can walk away at the end of a lease term if we have it.

Ms. BROWNLEY. Well thank you. And I agree. I think leasing based on the map that the GAO showed in terms of changing demographics across the country, I think leasing gives us the appropriate flexibility that we need to be able to change and move given the movement and where the greatest needs are. And I know that currently the GSA scores leasing for veteran facilities differently than they do for any other Federal government buildings. And can you comment on, I know I have a piece of legislation to try to fix that, but that seems to be one of the big barriers in terms of authorizing these leases, is that they, if it is a 20-year lease or a 30-year lease it is scored for the full cost of 20 years or 30 years in the first year, and that is the barrier. So can you comment on that? And do you recognize that there needs to be a fix?

Mr. SULLIVAN. Absolutely recognize there needs to be a fix. Secretary Shulkin challenged us a couple of months ago to meet with CBO, who is the scorer, as many people know, of these transactions. And we met with CBO and they told us in no uncertain terms that the way our leases are structured, and even if we change the way they are structured, there is nothing we can really do to the transaction that would have them change their score. So that is the legislative holdup. And I think the score on the legislation is probably around \$1 billion, I think, is what they came up with.

Ms. BROWNLEY. I apologize. I said GSA.

Mr. SULLIVAN. That—

Ms. BROWNLEY. I mean CBO.

Mr. SULLIVAN [continued]. —CBO, sorry.

Ms. BROWNLEY. But to Ms. Draper, do you have any comments on how these leases are scored and where you think improvements might be, or not?

Ms. DRAPER. We have, I have not really looked at that. So I would be unable to comment on that. But I could see if we have done work on that and provide you some additional information.

Ms. BROWNLEY. Okay. I think, you know, I just, I again just personally believe that this is something that we have got to fix. That this, the way it is scored, I do not know if anybody on the panel, Mr. Principi, maybe you know the history behind this? And why it was changed? I am not even sure exactly when it changed. But I have been told that it was changed a while ago, specifically just for VA facilities and no changes for any other Federal buildings.

Mr. PRINCIPI. Yes. I do not recall exactly when it was changed. I thought it was done by OMB in the 2000 timeframe, I believe. Maybe Mr. Sullivan knows. I do not.

Ms. BROWNLEY. Nobody knows the rationale for it, though?

Mr. SULLIVAN. CBO about four years ago, five years ago, just changed the way in which they treated these as operating leases and started scoring them over the entire term of the lease. I cannot come to explain how they changed their interpretation. I leave that to them to explain.



Ms. BROWNLEY. Well I think it is an important piece of this kind of overall discussion, is trying to really focus on this. And as we move forward in evaluating facilities and evaluating I think the advantages of leasing over building permanent structures so that we do have this nimbleness and flexibility. With that, I will yield back.

The CHAIRMAN. I thank the gentle lady for yielding. I will just make a quick comment that the way this is scored we have to give the CBO the Forrest Gump Award, stupid is as stupid does. Nobody in the world would score—anyway, I will yield now to Mr. Higgins.

Mr. HIGGINS. Thank you, Mr. Chairman. Mr. Sullivan, you have addressed the enhanced use lease program greatly to my colleagues. I would like to add that my office requested data from the last couple of months regarding identifying actual structures that were perhaps targeted for sale or destruction and ultimately last night we found that there was one in my state and none in my district. So my comment may apply more to my colleagues than to myself. But during the course of researching what we would do with those facilities if they existed in my district, we are concerned about veteran homelessness and transitional housing for our veteran brothers and sisters that struggle to, with reentry into civil endeavors when they leave the military. And many of these facilities have, you know, many rooms that could be considered a small apartment. They have kitchen facilities and laundry facilities and meeting facilities. And they could be remodeled into transitional housing for homeless veterans. So in the process of researching this, I spoke with veteran owned construction companies in my district, and every one of them was adamant that they would be willing to donate their services and their own private capital to remodel and restore these facilities. We also spoke with charitable services that work with homeless and indigent Americans. And they would be willing to lease the properties and maintain them once they were remodeled over a 20- or 30-year lease. So I would suggest that common sense solutions like this be considered regarding the structures that exist that are targeted for sale or destruction. Perhaps the relationship between the VA and the VHA and the public and private sector can include solutions that would cost the people's treasure virtually nothing and yet would provide an invaluable service for transitional housing for homeless veterans across the country. It does not affect my district because I do not have any structures. But perhaps some of my colleagues may consider this approach.

Ms. Draper, my question is for you regarding the means by which money is assessed, and personally I believe the money should follow the veteran, and I believe that we should move away from the mother ship structure that historically the VA and VHA has maintained. My district represents the highest density of veterans in the state but we do not receive the highest percentage of money. And this money is assessed according to the veteran population that is registered within the VA. But the veterans because of the need to travel to the mothership hospital, in in my case Alexandria, the veterans have lost faith in the system so they are not counted. They are not counted. The veteran himself is not counted. They are only counted and the money is aligned according to those

that are registered within the system. But we seem to be blind to the fact that so many thousands and thousands of our veteran brothers and sisters have become disenfranchised with the system. That is the problem that we are trying to fix here. So can you please speak to whether when assessing where assets are most needed, the VA considered the entire eligible veteran population or solely the enrolled veteran population? As we work to expand more care to veterans I think it is important that this money be assessed based on reality.

Ms. DRAPER. Well they use a couple of models. One is the veteran population model, vet pop, and then you know, looked at another model of demand for care and the resources that would be needed to supply that demand.

One of the things that we talked about in terms of the SCIP process, the long term planning process, is that try and match or align the need of facilities for services for the veteran population, one of the key weaknesses that we found is that sometimes writing the SCIP narratives, which is a third of the scoring process or the score, it really is often dependent on the ability of the writer to meet some of the goals of what VA has laid out rather than the merits of the project itself. So we found cases in the field where some facilities never had a SCIP project funded. So you know, there needs to be, that is the limitation of that planning process as well. It needs to be, you know, looking at the merits of the project itself versus somebody's ability to write the narrative.

Mr. HIGGINS. Thank you for your answer, ma'am. In the interests of time, I would like to ask that could my office provide questions, more detailed questions to you, ma'am, that we could expect answers to? And perhaps get to the bottom of this? Mr. Chairman, thank you for the time. I yield back.

The CHAIRMAN. I thank the gentleman for yielding. Ms. Kuster, you are recognized for five minutes.

Ms. KUSTER. Thank you very much. And I just want to pick up on my colleague's suggestion. We have an opioid crisis in New Hampshire. And one of the issues is transitional housing after treatment to continue the intensive outpatient treatment but to have a place to live. So I like your idea quite a bit.

My question about these 430 buildings that we are trying to address is that a significant hurdle for disposal of vacant and under-utilized buildings is finding lessees and buyers, as you talked about, because of the condition of the buildings. And my question is have you considered whether the VA would actually spend money to bring some of the buildings up to code? Or make them more usable perhaps for this type of transitional housing? Or other uses? And if so, or do you intend to simply demolish the buildings and use them, just sell the land? And the question relates to whether you have made any cost projects and whether you need any additional authorities or appropriations to take that approach?

Mr. SULLIVAN. At this point we do look at all the alternatives. As I think I mentioned earlier, we are going through a due diligence process on all of these 430-some odd buildings. And we will, you know, there has been an initial cut that has looked at the potential for both transitional and permanent housing and have not found a particular need as identified at the local level. But that

will be double checked as they go through due diligence. And if there is, then we would welcome in any of these places if there is a need and we can put together an operator and a developer to run these and to finance these that would be the perfect solution to us. We have encouraged it. We have done about 100 of these projects across the country. The more we can do and especially since they are all third party financed, you know, it does not take away from our core mission of having those resources to directly to veterans' care. So we would continue to do that. In terms of a cost estimate we, as we are doing the due diligence process we are developing a cost estimate based upon what the chosen course of action is in each of those buildings.

Ms. KUSTER. So I would just sing the praises of a program in my district in Nashua, New Hampshire, Harbor Homes, that has been a game changer for our veterans. We have recently achieved a functional zero for homelessness for our veteran population due in large part because of the transitional housing that is available. And I certainly know from the incredible stories of meeting with veterans how this has changed their life. I got to know one particular veteran, there was sort of a camp, they were living under a bridge. He was an older gentleman. But come to find out he was diabetic and he had no access to medication and no access to treatment. When he got into the transitional housing, got the treatment he needed, got some counseling, some job skills training, total turned his life around. And we learned that he had been middle management in a high company in our area. So he was reunited with his family. It is an incredible story.

The question that I have around this that concerns me, however, is that VA's request to cut the construction budget for fiscal year 2018 by 4.3 percent, or \$45 million, and what will this do in terms of your capital assessment for these properties going forward? And how can we help to make sure that you have both the authorities and the resources that you need?

Mr. SULLIVAN. Sure. The fiscal year 2018 budget for minor and major construction is what you are referring to. That would not have an impact on the disposal of these buildings.

Ms. KUSTER. So which budget would you be taking those funds from?

Mr. SULLIVAN. Depending upon the amount of money, it would probably come out of the non-recurring maintenance budget. And in 2018 I believe it is a \$809 million increase in 2018 to, I can get the exact, I think it is 1.8.

Ms. KUSTER. Okay.

Mr. SULLIVAN. But I do want to, you know, because it was raised earlier, the budget. I think the major and minor construction budget figures were based upon a total discretionary dollar figure that was given to VA. And VA in these limited budget resource times had to prioritize between direct medical care, research, and other things. And it was a functioning of balancing the appropriation request to Congress to live within a total cap and those, you know, these accounts were on the lower end of the scale, if you would.

Ms. KUSTER. Well I would agree with the Secretary that every tax dollar is sacred and we need to spend it wisely. But we want

to make sure that you have the resources to serve the veterans. So thank you. My time is up. I am yielding back.

The CHAIRMAN. I thank the gentle lady for yielding. General Bergman, you are recognized for five minutes.

Mr. BERGMAN. Thank you, Mr. Chairman, and thanks to all of you on the panel for being here today. This is so important because all the questions you have heard everybody is trying to make a positive difference. Mr. Sullivan, CBOCs, I see as a drive around the First District of Michigan, we have some nice new CBOCs that are built. Are they owned or leased?

Mr. SULLIVAN. They are all, they are all leased I think except for two or three.

Mr. BERGMAN. Okay. In the leasing process, could anyone tell me if they considered, regardless of where in the country, if they considered possible already existing space? Many of us have Native American tribes who have the health clinics that have excess space. Were those facilities in conjunction with our tribes considered before building or leasing a CBOC?

Mr. SULLIVAN. When we go out, and I am not the contracting expert and I can get you more details, but my understanding is that when we go out for a lease solicitation the first option that we ask people to consider is existing building, existing space somewhere rather than having to do a build to suit project. And some of the smaller leases, we do see that. Most of what I think people here were talking about earlier were all leases over a \$1 million. The smaller CBOCs that are managed and contracted for at the local medical center or VISN level, they do look at existing space first.

Mr. BERGMAN. But were the tribes given any priority?

Mr. SULLIVAN. I would have to check with contracting.

Mr. BERGMAN. Okay. I would like—

Mr. SULLIVAN. I do not—

Mr. BERGMAN. I would like you to take that for the record—

Mr. SULLIVAN. But we can get back to you.

Mr. BERGMAN [continued]. —and get back to me. Because as you know, our tribal members have a high, high, high participation rate, especially in wartime. And I believe we have a, not only an obligation but an opportunity to partner with those already existing medical facilities that are provided for. So that is, I would like you to look at that very closely going forward.

Mr. SULLIVAN. And there might also be the opportunity for a sharing agreement with the tribes or other entities instead of a real property instrument to be able—

Mr. BERGMAN. Absolutely. And thank you for using the word, because the more we get into the idea of shared services, shared services are something that are, number one, going to provide a higher quality of care or the housing. And number two, it is going to save those valuable dollars. We know that. And thank you for going down the shared pathway.

Different, kind of a different tack here, GAO claims, Mr. Sullivan, you are still the winner here.

Mr. SULLIVAN. Sure.

Mr. BERGMAN. That in, GAO claims that in 2016 VA reported 370 buildings that were either vacant or less than 50 percent occupied. However, last month the VA announced an initiative to begin

either repurposing or disposing of 430 vacant buildings over the next two years. Why did so many more buildings become vacant in the last year? And how many more buildings do you expect to become vacant or largely so in the next year? And why?

Mr. SULLIVAN. I think the reason why is can be fairly easily explained. Each year we go out to the local users of all of our facilities and we do an assessment and ask them to give us the status of their assets. All the spaces we own, all the owned space, and all the leased space. And in that data call we go out and ask them to say identify facilities that are vacant. So each year, and it closes at the end of the fiscal year, we get a report. And it takes about two months to process. So each December we put out a number of what the number of vacant buildings are and it is based upon the submissions that came in that year. So each year you will see some are added, some are taken off, because we have been disposing of about 100 of these a year over the last ten years. So the numbers will flex.

Mr. BERGMAN. Is there a checklist or anything that you, the VA works through when you start this process that, you know, some of us could view if we say, okay, here is what triggers it and we ask the following questions or the criteria?

Mr. SULLIVAN. Yes, I believe there is a validation process when they go out to validate the data in the field. I would be happy to provide whatever we have to you.

Mr. BERGMAN. Okay. Ms. Draper, was GAO able to determine costs for maintaining equipment, beds, and utility usage in unused portions of the VA medical centers?

Ms. DRAPER. We did not look at that for this current work.

Mr. BERGMAN. Okay. Thank you. And that is my last question. Mr. Chairman, I yield back.

The CHAIRMAN. Thank you, General Bergman. Mr. Correa, you are recognized for five minutes.

Mr. CORREA. Thank you, Mr. Chairman. First of all, I want to thank all of you, the panelists for being here today and to all the veterans here. Thank you for your service to our country.

I wanted to follow up on some of the questions of my colleagues, which are shared services and also in my district and my state thinking about how many vacant buildings do we have in California, Southern California? Number two, have we reached out to local, state, county, city services, governments to address again the issue of homeless vets? And are we looking at operating in silos or have we actually worked with a lot of those folks? Local municipalities, local counties, and the state, they are all raising taxes right now to address this homeless issue that continues to explode in our backyards. We are talking about 430 buildings here underutilized.

Mr. SULLIVAN. Yes, we do. One of the hallmarks I think of working with an enhanced use lease, especially on permanent or temporary housing, is that we actually work with the local public housing authority and work with the local cities and towns. Because in many of the cases some of the funding sources could come from tax credits locally or from other funding sources, as well as the operator of the facility has to be familiar with the local area and with the local providers. And in almost every case it is a local on the ground community provider who will come in and do that. I know

in California we have done that in West L.A. We opened up a facility in West L.A. a couple of weeks ago. We have four more that are slated, that are in process there, where we have developers—

Mr. CORREA. That is the West L.A. UCLA property?

Mr. SULLIVAN. Yes, working there with developers, nonprofits, to put in homeless housing for another 300 or 400 units in the next two years.

Mr. CORREA. Any other facilities in Southern California that you are working on?

Mr. SULLIVAN. I would have to get the list. I—

Mr. CORREA. I would love to see that data, if you have it.

Mr. SULLIVAN. Sure.

Mr. CORREA. And also in terms of the 430 facilities, we are all looking at taxpayer dollars here. We are all looking at cash flows, annual budgets. Yet I cannot help but think at the local level where in Southern California, my district, school districts 30 years ago where enrollment went down, sold a bunch of the schools. Enrollment went up. We had to go buy properties back at three or four times the price to make sure we had the capacity for new and emerging enrollment. I just want to make sure, and I am sure you are looking at that from a financial perspective, as you move ahead, you have got to make sure you budget yourself, save those taxpayer dollars, but also looking to the future in terms of our capacity to take care of our vets.

Mr. SULLIVAN. We are.

Mr. CORREA. Thank you, Mr. Chair. I yield back my time.

The CHAIRMAN. I thank the gentleman for yielding. Let us see, Miss Gonzalez-Colon, you are recognized for five minutes.

Miss GONZALEZ-COLON. Thank you, Mr. Chairman. And thank you, all Members of the panel, for being here. Mr. Butler, your testimony rightly notes that many of the VA medical centers are landlocked, which prevents them from expanding. Do you have any recommendations on how to assist those facilities to grow?

Mr. BUTLER. Well I think the VA should, those facilities should use existing processes in terms of SCIP and so forth to evaluate their current needs and then follow that process all the way through. The concern that we have is that process takes too long. And so VA needs to refine the process to ensure that whatever model facilities are using, that model can rapidly respond to the urgent and emergent needs available at the time.

Miss GONZALEZ-COLON. Thank you. Ms. Draper, in terms of your report, you make some reference to the short term growth in demand for the VA healthcare services followed by an eventual decline in the veteran enrollment. How would you suggest that the VA plan for that in the years ahead? And are you aware of any other Federal agency that are making plans for those kinds of declines in those kinds of enrollment, or similar challenges?

Ms. DRAPER. I think it gets to a lot of the discussion about ensuring that there is flexibility in what type of health services are being provided, either through bricks and mortar or through care in the community. And you know, as we reported in our report, there are some limitations with the process as it currently stands. You know, you are setting up a situation by not having an assumption in the planning process that a lot of the care is being shifted to care in

the community. So you are simultaneously developing capacity both in terms of what VA is doing and then what care in the community is being done. So, you know, when the population is starting to decrease then you are going to be left with some situations where you have over capacity and that is a concern that we explained in our report.

Miss GONZALEZ-COLON. Thank you. Mr. Sullivan, and this is kind of the same matter, with the problems we are facing with the recruitment of physicians and personnel to attend that demographic decline we are having in the veteran patients, what kind of strategic planning is the VA doing for new recruitment for healthcare services?

Mr. SULLIVAN. I am sorry. That is a little out of my lane. I do not know if Dr. Crump here—

Mr. CRUMP. Is your question about recruitment for providers?

Miss GONZALEZ-COLON. Yes.

Mr. CRUMP. There is a very aggressive approach. Even Dr. Shulkin, the Secretary, has been out speaking with medical schools, speaking with large organizations, requesting that people apply. We are also looking at flexibilities to be able to directly appoint medical center directors and VISN directors. So it is a very aggressive effort to recruit new providers into VA because we have a constant turnover.

Ms. DRAPER. And I can also address that. We actually have a report that will be coming out later this summer that looks at provider, physician recruitment and retention.

Miss GONZALEZ-COLON. We face that problem on the island. We lack a lot of specialists on the island and we are even bringing them from so many states. They do not want to move to the island. And we are attending not only the people from the island, but from the Virgin Islands, too. And in that manner, it is a little bit difficult to attend the patients that we have with the shortage of physicians.

In another area, I was a little bit surprised, Mr. Sullivan, to hear that VA is behind only from the DoD in terms of the, and the Department of the Interior, in terms of the numbers of historic properties. In that matter, are there any statutory or regulatory changes that could be made to lessen the burden of historic properties on the VA capital asset planning that we can make?

Mr. SULLIVAN. I think there are. I think we want to be fully compliant with historic preservation goals in the statutes that are required. I think what we would ask for is for a more expeditious process to speed that process up. Right now it can be extensive in some cases, which adds a lot of time to doing any transaction.

Miss GONZALEZ-COLON. If you want to make any direct recommendation of changes, please provide it.

Mr. SULLIVAN. Sure, we will. Thank you.

Miss GONZALEZ-COLON. Thank you. Thank you, Mr. Chairman. I yield back.

The CHAIRMAN. I thank the gentle lady for yielding. Ms. Rice, you are recognized for five minutes.

Miss RICE. Thank you, Mr. Chairman. Mr. Principi? Is that how you say your name? I just want to go back to a comment that you made when you were asked about what happened with the CARES

program and its elimination. You said that there were some political concerns. Can you just expound on that?

Mr. PRINCIPI. I think the problem is that politics got involved in some of the tougher decisions to close or realign medical centers. Canandaigua, New York, a 1,700-bed long term psychiatric facility built in 1932 at a time when we took veterans with serious psychiatric needs away from their homes, away from the cities, and placed them in a long term facility, much like we did with all Americans, not just veterans. And during the CARES process I noted that there were only, it had an average daily census of about 166 patients, less than ten percent of this magnificent, this huge, 100-acre campus with a 1,700-bed facility. Well when the decision was made to close that facility, it was stopped. And I think that is part of the process when there is not some teeth in this process.

But I think it is important to bear in mind, Representative, that the VA healthcare system, although it predates World War II, like 1932 and the 1920s when following treating tuberculosis in sanitariums those facilities became VA facilities in the twenties. Much of the infrastructure today was built after World War II to take care of 16 million veterans coming back from the War and then shortly thereafter the Korean War. So you have these facilities built in the forties and fifties when you needed 800-bed hospitals, maybe 2,400-bed hospitals in cities that you no longer need today because there has been such a significant shift in the way we care for people today.

So although Mr. Sullivan talked about the cost of empty buildings and underutilized buildings, I do not think that takes in to consideration could we do with new, modern, one new, modern healthcare medical facility in a city, as to three that were built in 1944? And I do not think the cost, I think the cost is much greater than the \$9 million or \$25 million the VA is spending today. And I think that is going to take a very comprehensive assessment, careful, open, transparent, data driven, visits to around the country to do it right. To look at the assessment, the needs, the medical needs of our veterans over the next ten to 20 years. I know that is difficult because healthcare changes daily. But I think you need an assessment like that and I urge the Committee to consider doing that.

Miss RICE. Well I think it is a very good recommendation. And I am going to say what you were I think too cautious and respectful to actually say. You know, we, a lot of us up here spend a lot of time with panelists like you and say, what can we do to help you? Well in this instance, in the subject matter that we are talking about right now, I think it is really clear what has to be done through all of your hard work, recommendations, you implementing it, you making the recommendations, you having, all of you, your recommendations. What we have to do up here in my humble opinion, and I think that, I feel very confident that if there is any Committee in Washington, D.C. that has the political courage to do what is necessary it is this one. What you are saying, and you were talking about a facility in New York, is that you need politicians like us to be courageous enough to make the case for why certain facilities have to be closed for whatever reason and not make it about abandoning veterans in their time of need. And that has al-



ways been the hot potato that no one ever wants to touch. And I think we have to, it is not enough for us to just sit here and ask you, what can we do to help you? We know what we can do to help this realignment that has to happen if we are fully going to enable the VA to go into a 21st Century medical treatment mode. So I just want to throw that out, Mr. Chairman. And I want to say that I am very grateful that we have your leadership and the leadership of Ranking Member Walz to help us do the right thing here. Thank you, and I yield back.

Mr. PRINCIPI. If I can just add very briefly, I think if we do not do that, and it would be collective, I think the VA will fail and will fail the needs of veterans. I do not think this can be sustained ten or 15 years. Looking at the demographics of the veteran population, World War II, all but gone; Korea, almost all but gone; my generation that fought in Vietnam, getting up there. There is going to be a dramatic decline in demographics of veteran population, the shifts in where they are moving to, this vast infrastructure, the cost to the taxpayer. I think we need to look at it very carefully.

The CHAIRMAN. Well the Secretary is doing real well. He started talking about Vietnam here, guys. He is meddling now, when he was talking about our age guys. Mr. Poliquin, you are recognized for five minutes.

Mr. POLIQUIN. Thank you, Mr. Chairman, very much. I would like to salute Miss Rice for what she said. We have got to have the guts to do what is right here. And it is all about taking care of our veterans. You know what really drives me crazy? Is that we were just dealing, Mr. Chairman, recently with a similar issue at the entire Federal government level. There are about 3,120 vacant and unused office buildings owned by the Federal government, not just the VA. You have about 340 of them, but it is about 3,100. It is costing the American taxpayers \$1.7 billion per year to maintain 3,120 vacant and unused office buildings. Office buildings, old barracks and what have you. You have got to keep, you have got to make sure they are heated, in some cases, right, if they are in the northern climates like Maine or Minnesota. Or you have got to make sure the roofs are not leaking. Then you have the liability with them. So what the heck could we do with that \$1.7 billion per year? Instead we are hanging on to these darn things.

Now let us drive down, Mr. Sullivan, a little bit and make sure I understand this. You folks have about 430 buildings that are vacant or unused. By the way, six of them are in Togus, Maine in Augusta, which is our only VA hospital. And we love Togus. We are watching them closely. But we love Togus.

Mr. SULLIVAN. We do too.

Mr. POLIQUIN. Good. And someone said that. I do not know who said that. But anyway. But we have six right there on campus. So my question is if you are spending about \$7 million a year, or whatever you said, Mr. Secretary, \$7 million a year to maintain these buildings, and you are going to get rid of them over the next couple of years. I understand that. Correct? And you have the authority to do that, right? David does.

Mr. SULLIVAN. Correct.

Mr. POLIQUIN. Secretary Shulkin has the authority to do that. Okay. Then what about this Paris Hotel? I want to close the loop

on this. I think Mike Coffman has a bill, Mr. Chairman, that gives Mr. Shulkin the authority to sell a hotel that you said, Mr. Sullivan, is worth \$35 million—

Mr. SULLIVAN. Correct.

Mr. POLIQUIN [continued]. —and we are getting \$350,000 a year in rent. That is a one percent return. What are we in that business before? That is the most ridiculous thing I have ever seen in my life. Right? But you have, Mike is going to drop that bill, right? So we can get rid of that hotel—okay. Good. So we are getting there.

Now I think Jack Bergman asked this question, Mr. Sullivan. I want to make sure I get this. As you proceed along this process, or Mr. Shulkin does with your help, I want to make sure this Committee, if I may, Mr. Chairman, is informed on how you are doing. Because the next time you are going to be here, I am going to ask you that question. So is there a process in place so we know you are on schedule to dispose of these buildings? Because every dollar we save, every asset that we are not maintaining, can go back into helping our kids that come back from combat with wounds, and so forth, and so on.

Mr. SULLIVAN. We plan to have a periodic update. Probably—

Mr. POLIQUIN. What is periodic?

Mr. SULLIVAN. Probably quarterly.

Mr. POLIQUIN. Okay.

Mr. SULLIVAN. That we are providing directly to the Secretary. And then we would be happy to provide that to the Committee if you desire.

Mr. POLIQUIN. I desire.

Mr. SULLIVAN. Okay. We will do it.

Mr. POLIQUIN. Okay. With the Chairman's blessing, I desire.

Mr. SULLIVAN. And I would like to say, at Togus, you know, an example of, an enhanced use lease that we just, awarded about a month ago for these housing facilities that are up there—

Mr. POLIQUIN. Great.

Mr. SULLIVAN [continued]. —is a good example of—

Mr. POLIQUIN. Yeah.

Mr. SULLIVAN [continued]. —getting the community to come in and take in that case it was not unneeded buildings, it was unneeded land.

Mr. POLIQUIN. Okay.

Mr. SULLIVAN. And now they are now having permanent housing at that site.

Mr. POLIQUIN. Great. And you know, what happens also, if I may, is when we are disposing of these buildings that we do not need and preventing us from taking better care of our men and women in uniform, is that these assets go back on the tax rolls in local towns and cities and they generate tax revenues if they are repurposed. That is good. We do not have a government unless we have tax revenues. Let us juice the tax revenues, right? It helps everybody.

Next question. I represent one of the most rural parts of America. Tell me how you folks are retooling the VA to provide care for those in rural areas. Let us not forget rural America. About a third of our country lives in rural America and we provide a proportionately large number of our veterans, of those that serve in the mili-

tary from rural areas because we know how to use firearms and we know how to shoot straight.

Mr. SULLIVAN. I would ask Dr. Crump to comment on that.

Mr. CRUMP. I will give you two examples of what we are doing to address—

Mr. POLIQUIN. Speak up, please. My ears are so bad.

Mr. CRUMP. Sorry. I will give you two examples of what we are trying to do to address the needs of veterans in rural areas. First we have an Office of Rural Health. And one of the things they do is focus primarily on the needs of those veterans, looking at different methodologies, sometimes innovative ways. We are putting resources out there to all of the VA medical centers, giving them the opportunity to request additional funding for things like telehealth hubs for mental health, for primary care.

Mr. POLIQUIN. I am almost out of time and Mr. Roe is very strict on time. So I am going to get right to the chase.

Mr. CRUMP. Okay.

Mr. POLIQUIN. When it comes to these assets that are underperforming assets and costing us money, how can this issue help rural veterans?

Mr. CRUMP. We are conducting a plan for a methodology that—

Mr. POLIQUIN. When is that plan going to be ready?

Mr. CRUMP. September—to look at a market by market analysis—

Mr. POLIQUIN [continued]. Okay. So that is three months.

Mr. CRUMP. —market by market analysis of the services and the needs. The needs of the veterans and the services available in every market, and then optimize that plan so that we can deliver that care. A combination of direct care delivery by VA—

Mr. POLIQUIN. Got it.

Mr. CRUMP [continued]. —telehealth, partnerships, leases—

Mr. POLIQUIN. Thank you, sir. And early September or late September?

Mr. CRUMP. It will begin in September.

Mr. POLIQUIN. When is it going to be done?

Mr. CRUMP. Next September. That is to do 90—

Mr. POLIQUIN. Why do you not start it now and finish it this September?

Mr. CRUMP. We are completing the pilot and developing the methodology now. We need to socialize that with the veteran—

Mr. POLIQUIN. Good. Our staff will be in touch with you folks to make sure we can see if there is any way we can speed this up. Thank you very much, doctor.

The CHAIRMAN. Thank you, Mr. Poliquin. Mr. Banks, you are recognized for five minutes.

Mr. BANKS. Thank you, Mr. Chairman. I will be brief. I know, Mr. Sullivan, you have already addressed questions about public-private partnerships. But I wonder if you could be more specific? Get into the weeds with us a little bit as policy makers on what greater flexibility can we provide you to enhance public-private partnerships to provide more opportunities for you to partner with the private sector on facilities across the country?

Mr. SULLIVAN. Sure. A little bit in the weeds. But we believe that there is a great market for us out-leasing existing facilities or land

to a private entity and having them either upgrade them or replace them or bring in another complementary private sector entity on the same campus, which would allow them to in essence cross-subsidize the development costs of renovating a building or providing a new building.

Right now we do not have the authority to out-lease any of our property to undertake that. And if you are looking at developing or setting up financing, there has to be an interest in the property that the private entity can take to the bank, if you will, and get financing. So having that out-lease authority would allow us to do that and we would enter into an agreement where we could occupy all of the building or a portion of the building, or all of the campus or a portion of the campus, in the long term.

That will work where there is a market for this. It will not work at every site. So that is when I said earlier we need a whole, if you will, suite of tools. Because if there is a market in the private sector for the property and it is valuable, you can trade off that to have a public-private venture done at that site. If you have property that is in some place that has very low real estate value, very low private interest in anything going on at the site, it is going to be pretty impossible to do a public-private venture unless someone is willing to come in and donate all of the money.

Mr. BANKS. How can we help you and give you that out-leasing authority? Is that legislative? Is that—

Mr. SULLIVAN. Yes, it is. It would require legislation.

Mr. BANKS. Okay. Are you aware, have there been—I am the new kid on the block on the Committee. Have there been efforts to give you that authority?

Mr. SULLIVAN. We had that authority at one point. It expired. It was renewed with this Committee's help to focus on housing at the time. And again, CBO is a challenge to get this legislation through, as it is with many capital related items. So expanding the EUL authority in some form would help do that. And there are various gradations of that legislation. You know, the more you give us the higher the score may be for the legislation.

Mr. BANKS. Right. I look forward to working with you on that.

Mr. SULLIVAN. I am happy to work with anyone on that.

Mr. BANKS. Thank you very much. Mr. Chairman, I yield back.

The CHAIRMAN. I thank the gentleman for yielding. First of all, I want to thank the panel, for you all being here today. It has been very, very instructive and constructive. And I think this is the beginning of a dialogue that is going to, that needs to continue and will continue. I now will yield to Ms. Brownley for any closing remarks.

Ms. BROWNLEY. Well I thank you, Mr. Chairman, for having the hearing. I think it has been a productive one and the beginning of a longer conversation that we are going to have to have over all of this. But I do think we need to expand the conversation from not just obsolete facilities but, what are the opportunities around public-private partnerships? The leasing issues? All of this I think is, under the same umbrella of, how we move forward and be in a mode of continuous improvement as it relates to our facilities. Where we, you know, as time goes on, how are we going to remove facilities and enhance facilities where they are needed in a more

timely way? So with that, I would yield back, and thank you again for the hearing.

The CHAIRMAN. Thank you all. And again, I appreciate the panel being here. You all have been very helpful. And this is a very complex, emotional issue. And it is going to have to be done, as Secretary Principi said, in a very thoughtful way, an open, transparent way, where all, everyone who is involved has input. And I can just tell you that when you live in rural America, and Mr. Poliquin mentioned this, you know, in rural America where I live we are seeing businesses shuttered. We do not see the growth that you see in other areas. And when you see a public facility, whether it is a post office or whether it is a school, an indication that your community is dying, and not growing. And you see a VA close or taking buildings down, it affects the whole community. I totally understand that. And we have to be sensitive to that.

But we also have to be sensitive to the fact that the mission of the VA is to provide healthcare, the very top quality healthcare we can to our veterans, our servicemen and women who have served this great country. And I think Ms. Brownley brought up a great point, several great points, about using leasing where you can be more nimble and put the CBOCs and outpatient clinics where much care is given where the veterans are, actually are. And the demographics, as I think was pointed out, Ms. Draper pointed out, are changing. Not just for veterans, but for the American population. I mean, Texas in 2010 picked up four congressional seats. That is three million people that moved into Texas. That is more demand. Probably many of them are veterans.

You know, I think the capital needs and we are looking at a \$4 billion a year, \$50 billion deficit, it looks like. And we are spending around \$2 billion a year. I think we need the information of where do we need those capital assets before we go out and just build a bunch of stuff and then realize, oops, we have put this in the wrong place. So I think that needs to be done. And the VA's track record on capital has been spotty when you look at Denver, and New Orleans, and Orlando, and so forth. And we know we can do better. Just the leasing of a major lease, I read in the documents that I was given that it takes nine years from the time the VA plans it to the actual activation of the lease, whereas the private sector is three years. We have to get better, and we will. I think we certainly will with the leadership that we have.

And I think one of the things you have to do is involve the veteran community when we are making these decisions. What do the veterans want the VA to look like and what services do they want? And I think they are actually telling us by where they are going to get their care.

So I cannot thank you enough. This is not something that is going to get a lot of publicity and nobody is going to go home to the Kiwanis Club and say I am talking about VA assets. I mean, that is like talking about the fiduciary rule, what I got to talk about on the other Committee that I am on. But it is incredibly important for the future of the VA and how we care for our veterans.

And with that, I ask unanimous consent that all Members have five legislative days to revise and extend their remarks and include

extraneous material. Without objection, so ordered. The hearing is adjourned.

[Whereupon, at 11:46 a.m., the Committee was adjourned.]

## A P P E N D I X

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### **Prepared Statement of The Hon. Anthony J. Principi**

Mr. Chairman, Ranking Member Waltz and members of the Committee, good morning. Thank you for this opportunity to testify on an issue of great importance to the VA and our Nation's veterans.

Medical care is a key component of the benefits and services enacted by Congress in recognition of the sacrifices of the men and women whose service in uniform preserved and protected our Nation's freedoms.

Neither medical science nor the veteran population is static and unchanging, and VA must always provide veterans with modern, high-tech facilities to offer them high quality health care.

The department will fail to honor our Nation's commitment to its veterans if VA's medical system does not evolve with the times.

VA is a proud organization with a great history. I was honored to be associated with the department, both as Secretary and as Deputy Secretary.

VA's partnership with medical schools, begun in 1945, revolutionized the way medicine is taught in America.

VA researchers led the way in developing effective treatments for tuberculosis, schizophrenia, and hypertension.

Three VA researchers have won Nobel Prizes; seven have won Lasker awards.

The department has made an enormous contribution to American health care-and has been a lifeline for tens of millions of veterans.

But while VA has a storied past and a turbulent present, many VA medical centers were designed and built in an era in which medical care was synonymous with hospital care. It made sense, in the 20th Century, to define our nation's health care commitment to most veterans as access to a hospital bed to the extent beds were available.

But American medicine-and VA health care-has transformed itself from hospital-centered to patient-centered treatment. Most veterans, like most Americans, see their physicians on an outpatient basis, and most treatment is provided by prescription drugs.

VA medicine has kept up with, and sometimes led, these innovations.

As a result, the number of VA outpatient visits increased from 46.5 million in Fiscal Year 2002 to 92.4 million in Fiscal Year 2014, while in that same period the number of inpatient admissions increased only from 564,700 to 707,400.

While the practice of VA medicine has evolved, VA's medical infrastructure has not kept pace. VA facilities are out of step with changes in the practice of medicine, with demographic changes in the veteran population, and with statutory changes in VA's health care benefits packages.

Mentally ill patients, for example, are no longer consigned to remotely located, thousand-bed asylums for the remainder of their lives. Treatment for tuberculosis no longer involves lengthy institutionalization.

In addition, millions of veterans, following the population migration patterns of the nation, moved to the South, the West, and the Southwest.

And as GAO noted in its recent report on VA Real Property, the new Choice program has also reduced the need for some facilities and services VA offers.

If VA does not realign itself, and close its unneeded facilities, the current decline in the veteran population will make many VA medical centers museums of the past-not the guideposts for the future they should be.

When I became VA Secretary in 2001, President George W. Bush reminded me that every dollar my agency spent is a dollar taken out of someone else's hard-earned pay. It's not how much money you are given in your budget that's important, he said-it's whether you spend that money wisely.

We are stewards of the public trust, he concluded, and we must never forget that. I had the opportunity to recall his words a short time later, when I was stuck in traffic in New York City. As my car idled in front of VA's Manhattan hospital,

I looked up at the hospital's patient bed tower. Among the hundreds of windows looking out on First Avenue, only a handful were lit. I didn't know what to make of it.

I learned the Manhattan VA hospital was one of many VA built in the 1950's to handle the influx of ill and injured World War II and Korean War veterans. It once held 800 veterans, as did nearby hospitals in Brooklyn and the Bronx. I was told the three hospitals that night were caring for only 283 veteran patients-all together. All the other beds were empty-and there were tens of thousands of empty beds throughout VA's system.

Accordingly, I commissioned a comprehensive assessment of VA's capital infrastructure and the demand for VA health care. The process was called Capital Asset Realignment for Enhanced Services (CARES), and it was modeled on DoD's infrastructure review process.

The CARES commission, which completed its work in 2004, offered sound recommendations for realignment and allocation of the Department's capital assets to meet demand for VA's services over the next twenty years. Unfortunately, the CARES and DoD processes differed in one specific way. Under CARES there was no requirement for Congress to adopt or reject the commission's final recommendations as a package.

As a result recommendations for some needed new hospitals and outpatient clinics were accepted; most of those to close or realign the mission of facilities were rejected.

I know that the difficulties of agreeing to such a procedure for members of Congress cannot be overstated. Having served as Chairman of the 2005 Defense Base Closure and Realignment Commission I know firsthand from visiting many of the military installations slated for closure or realignment how trying this process is for them.

The words "closure" and "realignment" are easy to write on paper, but they have profound effects on communities, and the people who bring those communities to life.

But VA is spending too much money on bricks and mortar, rather than doctors and nurses. VA's current budget request is for \$186.5 billion; in my last year as Secretary, in Fiscal Year 2005, that figure was \$69.4 billion-a 268 percent increase.

We are doing a disservice to the veterans VA is charged to serve, and to the American people, if those resources are not used wisely and well.

Our nation simply cannot afford to maintain a vast infrastructure built for a different time in health care delivery that was to care for tens of millions of veterans as they returned from World War II, Korea and Vietnam-and even from the Civil War, the Spanish American War, and World War I.

A full review of VA infrastructure is the right thing to do. One that is open, transparent and apolitical. Those impacted deserve no less.

Thank you.

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#### **Prepared Statement of Roscoe G. Butler**

Chairman Roe, Ranking Member Walz, and distinguished members of the committee, On behalf of our National Commander, Charles E. Schmidt, and the over 2 million members of The American Legion, we thank you for this opportunity to testify regarding The American Legion's views on "Care Where It Counts: Assessing VA's Capital Asset Needs".

Each year since 2003, The American Legion System Worth Saving (SWS) program has conducted site visits to VA Health Care facilities across the country and one thing we find in common is that VA has an enormous amount of aging buildings that are either underutilized or vacant. VA has a large inventory of buildings that are over a half-century old resulting in significant costs for upgrades and needed replacement of many parts of the facilities aging infrastructure.

In 1866, the United States Congress established the National Home for Disabled Volunteer Soldiers (NHDVS), the precursor of the VA, to provide medical and other facilities for veterans of the American Civil War. Three centers were established in the following years: the Eastern branch in Togus, Maine, the Central Branch in Dayton, and the Northwestern Branch in Milwaukee, Wisconsin. The Dayton facility was the administrative center of the home and its principal commissary. Today these facilities still deliver health care to our nation's veterans, and all have been designated by the National Historical Society as a historical site.

Medical Centers like the Phoenix VA, which first opened its doors in 1951 was built on 27 acres of the Indian School Reservation. After the medical center had



been built, the community was built around the medical center leaving the medical center landlocked resulting in VA's inability to expand their footprint which is the case with a lot of VA properties.

Today, the Veterans Health Administration (VHA) is the largest integrated health care system in the United States, providing care at 1,233 health care facilities, including 168 VA Medical Centers and 1,065 outpatient sites of care of varying complexity (VHA outpatient clinics), serving more than 8.9 million veterans. In spite of the exceptional health care VA provides, its aging infrastructure with a number of buildings being underutilized or vacant, creates problems for VA to maximize the use of its capital assets.

In a 2015 House Veterans Affairs Committee (HVAC) budget hearing, Secretary McDonald said that the VA had 336 buildings across the country that are less than half-occupied, and many are not being utilized to their full potential. Additionally, it apparently costs more than 24 million dollars a year to maintain these buildings. Secretary McDonald stated "VA cannot be a sound steward of the taxpayers' resources with the asset portfolio that we're currently carrying," McDonald told lawmakers. "No business would carry such a portfolio. Veterans deserve much better. It's time to close the VA's old substandard and underutilized infrastructure."<sup>1</sup>

According to information provided by VA in FY2016, VA had 403 vacant buildings at an annual operating cost of \$6,674,227 and 784 underutilized buildings at an annual operation cost of \$20,266,271. VA defines an underutilized building as an individual building that is occupied and in use, but the function(s) housed there do not require the full amount of space in the building to operate.

If there was unlimited funding, the easy answer would be to dispose of all of VA's vacant buildings and build new modern facilities but the reality is funding is not unlimited. Based on a June 22, 2017 VA news release, Dr. Shulkin announced plans to dispose of all of its vacant buildings over the next 24 months.<sup>2</sup> According to Dr. Shulkin, if it cannot sell, re-use or otherwise dispose of the property, the plan is to knock them down and clear the site for something else. The American Legion has reviewed the Government Accountability Office (GAO) April 2017 report entitled, *VA Should Improve Its Efforts to Align Facilities with Veterans' Needs*.<sup>3</sup>

The American Legion agrees that over time there has been many changes which have impacted VA's ability to align its medical facilities and services in order to meet the needs of our nation veterans. According to GAO geographic shifts in the veteran population, changes in health care delivery, and an aging infrastructure affects the Department of Veterans Affairs' (VA) efforts to align its services and real property portfolio to meet the needs of veterans.

Since VA began treating veterans, eligibility has expanded from treating service-connected veterans to providing care to all veterans who are eligible to enroll in the VA Health Care System. As a result, the need for increased space in the VA healthcare systems across the country has not been able to keep up with the shifting veteran population.

When The American Legion System Worth Saving team is out conducting System Worth Saving Site visits, VA employees often express concerns about the lack of space, the amount of time it takes to acquire lease space, and the time it takes to build a new facility or community-based outpatient clinic. VA employees express concerns about VA's Strategic Capital Investment Planning (SCIP) process. According to GAO, VA is aware of many of the limitations of the SCIP process-as the Independent Assessment found many of the same limitations and made recommendations to address them, but VA has taken little action. Specifically, in 2015, the Independent Assessment found that SCIP's scoring and approval processes and time frames undermined VA's capital planning and prioritization process.

In 2016, The American Legion renewed Resolution No. 136, Strategic Capital Investment Planning Program, which urges Congress to provide increased appropriations annually to address Department of Veterans Affairs construction deficiencies and gaps identified by VA's Strategic Capital Investment Planning program; VA includes activation costs in their future SCIP cost projections and allocations, so VA's budget will not have to offset this lack of national funding, and VA continues to be

<sup>1</sup> Military Times (February 2017): VA looking at its own version of BRAC

<sup>2</sup> VA news Release: VA announces plan to dispose of or reuse all its vacant buildings in 24 months

<sup>3</sup> GAO Report No. 17-349 (April 2017): VA Should Improve Its Efforts to Align Facilities With Veterans Needs

transparent about SCIP's progress by publicly posting information about projects and costs on an annual basis.<sup>4</sup>

Based on The American Legion's review, addressing VA's capital asset needs is not a new phenomenon. There have been numerous government reports over the last 26 years addressing this topic to include the following GAO reports:

- 1991- GAO/T-HEHS-00-91, VA Is Struggling to Respond to Asset Realignment Challenges<sup>5</sup>
- 2000 - GAO/T-HEHS-00-88 - VA Health Care: VA is Struggling to Address Asset Realignment Challenges<sup>6</sup>
- 2003 - GAO-03-1103R - VA Health Care: Framework for Analyzing Capital Asset Realignment for Enhanced Services Decisions<sup>7</sup>
- 2005- GAO-05-429, Key Challenges to Aligning Capital Assets and Enhancing Veterans' Care<sup>8</sup>
- 2007 - GAO-07-048, Overview of VA's Capital Asset Management
- 2009 - GAO-09-686T, Overview of VA's Capital Asset Management<sup>9</sup>
- 2017 - GAO-17-349, VA Should Improve Its Efforts to Align Facilities with Veterans' Needs<sup>10</sup>

In 2004, the Veterans Affairs Capital Asset Realignment for Enhanced Services Commission (CARES) delivered their report to Congress.<sup>11</sup> All of these reports included recommendations for improvements. Since the 1999 report was issued, GAO continues to report on deficiencies in the Department of Veterans Affairs Capital Alignment and Asset Needs.

The American Legion is concerned that VA has not routinely engaged Veteran Service Organizations (VSOs) in discussions about their plans to address VA's capital asset needs. VA must do a better job in engaging VSOs in these discussions. Twenty-six years later, and we are still trying to find solutions to VA's Capital Asset Needs. For God and Country, The American Legion hopes it doesn't take another twenty-six years to find solutions to VA's Capital Asset Needs.

### Conclusion

As always, The American Legion thanks this Committee for the opportunity to explain the position of the over 2 million veteran members of this organization. For additional information regarding this testimony, please contact Mr. Matthew Shuman, Director at The American Legion's Legislative Division at (202) 861-2700 or mshuman@legion.org.

### Prepared Statement of Debra Draper

#### VA REAL PROPERTY

#### Planning and Communication Improvements Could Help Better Align Facilities with Veterans' Needs

Chairman Roe, Ranking Member Walz, and Members of the Committee:

I am pleased to be here today to discuss our April 2017 report on the Department of Veterans Affairs' (VA) efforts to align its medical facilities and services.<sup>1</sup> As you know, VA operates one of the largest health care systems in the United States, providing care to more than 8.9 million veterans each year. VA is also one of the largest federal property-holding agencies. In September 2014, VA's reported inventory

<sup>4</sup>The American Legion Resolution No. 136 (Aug. 2016): Strategic Capital Investment Planning Program

<sup>5</sup>GAO Report No. T-HEHS-00-91 (April 2000): VA Is Struggling to Respond to Asset Realignment Challenges

<sup>6</sup>GAO Report No. T-HEHS-00-88 (April 2000): VA Is Struggling to Address Asset Realignment Challenges

<sup>7</sup>GAO Report (August 2003): VA Health Care: Framework for Analyzing Capital Asset Realignment for Enhanced Services Decisions

<sup>8</sup>GAO Report No. 05-429: (August 2005): Key Challenges to Aligning Capital Assets and Enhancing Veterans' Care

<sup>9</sup>GAO Report No. -09-686T (June 2009) Overview of VA's Capital Asset Management

<sup>10</sup>GAO report No. 17-349 (April 2017): VA Should Improve Its Efforts to Align Facilities with Veterans' Needs

<sup>11</sup><http://www.goldenwest.net/veteranstown/doc/CARES-Final-Report.pdf>

<sup>1</sup>GAO, VA Real Property: VA Should Improve Its Efforts to Align Facilities with Veterans' Needs, GAO 17 349 (Washington, D.C.: Apr. 5, 2017).

included 6,091 federally-owned and 1,586 leased buildings. However, in recent decades, the veteran population and preferences have shifted. VA has recognized this and the need to modernize its aging infrastructure and align its real property assets to provide accessible, high-quality and cost-effective services to veterans.

Aligning VA facilities to improve veteran access to services integrates two of GAO's high risk areas: veterans' health care and federal real property. In 2015, GAO placed veterans' health care on its High Risk List due to persistent weaknesses and systemic problems with timeliness, cost-effectiveness, quality, and safety of the care provided to veterans.<sup>2</sup> In 2003, GAO placed federal real property management-including management of VA real property-on its High Risk List due to long-standing challenges including effectively disposing of excess and underutilized federal property.<sup>3</sup>

Today I will summarize the findings from our April 2017 report including (1) the factors that affect VA facility alignment, (2) the extent to which VA's capital-planning process facilitates the alignment of facilities with the veteran population, and (3) the challenges VA faces in its alignment activities. In addition, I will highlight key actions that we recommended in our report that VA can take to improve its ability to plan for and facilitate the alignment of its facilities with veterans' needs.

For our report, we reviewed VA's facility-planning documents and data and interviewed VA officials in headquarters and at seven medical facilities selected for their geographic location, veteran population, and past alignment efforts. We also evaluated VA's actions against federal standards for internal control, federal capital-acquisition guidance, and GAO-identified best practices for capital planning.<sup>4</sup> Additional information on our scope and methodology is available in our report. The work on which this testimony is based was conducted in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

### **Facility Alignment Is Affected by Shifting Veteran Populations, Evolving Health Care Delivery, and an Aging Infrastructure**

Geographic shifts in the veteran population, changes in health care delivery, and an aging infrastructure affect VA's efforts to align its services and real property portfolio to meet the needs of veterans. For example, a shift over time from inpatient to outpatient care will likely result in underutilized space once used for inpatient care. In such instances, it is often difficult and costly for VA to modernize, renovate, and retrofit these older facilities. In June 2017, VA reported that its facility inventory includes 430 vacant or mostly-vacant buildings that are, on average, more than 60 years old, and an additional 784 buildings are underutilized.

The historic status of some VA facilities adds to the complexity of converting or disposing of them. In 2014, VA reported holding 2,957 historic buildings, structures, or land parcels-the third most in the federal government after the Department of Defense and the Department of the Interior. In some instances, it may be more expensive to renovate than demolish and rebuild outdated facilities. In other cases, however, there may not be an option to demolish if these buildings are designated

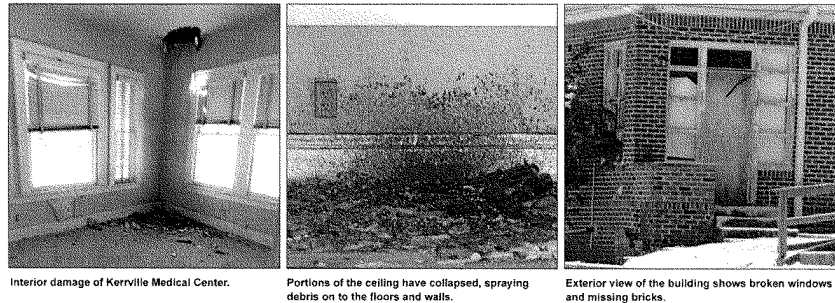
<sup>2</sup>GAO, High-Risk Series: An Update, GAO 15 290 (Washington, D.C.: February 2015). GAO maintains a high-risk program to focus attention on government operations that it identifies as high risk due to their greater vulnerabilities to fraud, waste, abuse, and mismanagement or the need for transformation to address economy, efficiency, or effectiveness challenges. See, for example, GAO, VA Health Care: Actions Needed to Improve Newly Enrolled Veterans' Access to Primary Care, GAO 16 328 (Washington, D.C.: Mar. 18, 2016) and GAO, VA Mental Health: Clearer Guidance on Access Policies and Wait-Time Data Needed, GAO 16 24 (Washington, D.C.: Oct. 28, 2015). See also, for example, Department of Veterans Affairs, Office of Inspector General, Veterans Health Administration, Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System, Report No. 14-02603-267 (Washington, D.C.: Aug. 26, 2014) and VA, Department of Veterans Affairs Access Audit, System-Wide Review of Access, Results of Access Audit Conducted May 12, 2014, through June 3, 2014.

<sup>3</sup>See GAO, High-Risk Series: Federal Real Property, GAO 03 122 (Washington, D.C.: January 2003).

<sup>4</sup>See GAO, Standards for Internal Control in the Federal Government, GAO/AIMD-00-21.3.1 (Washington, DC: November 1999), and GAO, Standards for Internal Control in the Federal Government, GAO 14 704G (Washington, D.C.: September 2014), Office of Management and Budget, Circular No. A-11: Preparation, Submission, and Execution of the Budget, July 2016, and GAO, Streamlining Government: Questions to Consider When Evaluating Proposals to Consolidate Physical Infrastructure and Management Functions, GAO 12 542 (Washington, D.C.: May 23, 2012).

as historic. For example, planning officials at four medical facilities in our review told us that state historic preservation efforts prevented them from demolishing vacant buildings, even though these buildings require upkeep costs and pose potential safety hazards. (See fig. 1.)

Figure 1: Example of a Deteriorating Historic Vacant Building at a Department of Veterans Affairs' (VA) Medical Center, July 2016



Source: GAO. | GAO-17-745T

### Limitations in VA's Capital-planning Processes Impede Its Alignment of Facilities

Two of the planning processes VA uses to align its facilities—VA's Strategic Capital Investment Planning (SCIP) and the VA Integrated Planning (VAIP)—have limitations.<sup>5</sup>

Implemented in fiscal year 2011 as a pilot project, the VAIP process's goal was to identify the best distribution of health care services for veterans; where the services should be located based on the veterans' locations and referral patterns; and where VA should adapt services, facilities, and health care delivery options to better meet these needs as determined by locations and referral patterns.

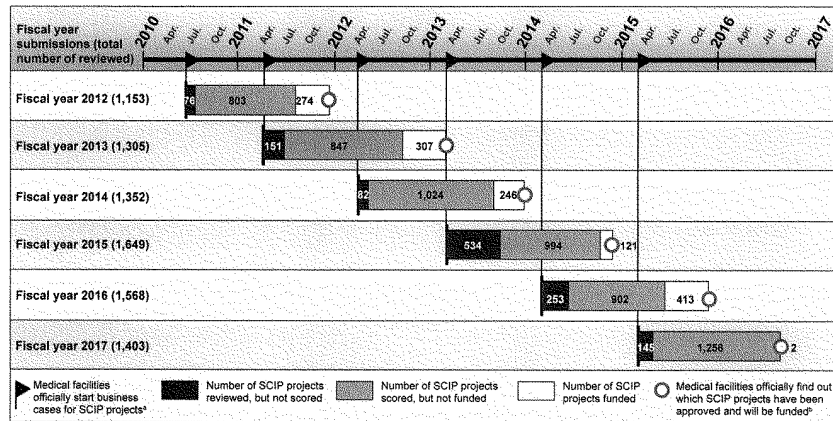
#### SCIP Process

VA relies on the SCIP process to plan and prioritize capital projects system-wide, but SCIP's limitations—including subjective narratives, long timeframes, and restricted access to information—undermine VA's ability to achieve its goals. For example, the time between when planning officials at VA medical facilities begin developing the SCIP narratives and when they are notified that a project is funded has taken between 17 and 23 months over the past 6 fiscal-year SCIP submissions.<sup>6</sup> (See fig. 2.) As such, VA routinely asks its facility planners to submit their next year's planned project narratives before knowing if their project submissions from the previous year have been funded.

<sup>5</sup>Established in 2010, the goal of SCIP is to identify the full capital needed to address VA's service and infrastructure gaps and to demonstrate that all project requests are centrally reviewed in an equitable and consistent way throughout VA, including across market areas within VA's health care system. Annually, planners at the medical facilities develop 10-year action plans for their respective facilities, which include projects to address gaps in service identified by the SCIP process. Medical facility officials then develop more detailed business plans for the capital improvement projects that are expected to take place in the first year of the 10-year action plan. These projects are validated, scored, and ranked centrally based on the extent to which they address the annual VA-approved SCIP criteria using the assigned weights.

<sup>6</sup>The scoring of submitted projects includes both narrative responses that are evaluated (about one-third of the overall score) and data-driven scoring based on gap closure (the remaining two-thirds of the overall score).

Figure 2: Overlapping Timelines of the Last 6 Fiscal Years of the Strategic Capital Investment Program's (SCIP) Project Submissions and the Number of Submissions



- (a) Although planning officials at VA medical facilities obtain initial information from SCIP about what gaps they need to address, they do not officially start developing the narratives until they receive a request from VA to submit a project for SCIP scoring and approval. Officials from the office that oversees SCIP told us that facilities usually have access to the tools for submission about a week prior to the request date.
- (b) Medical facilities officially find out which major (over \$10 million) and minor construction (under \$10 million) SCIP projects are approved and will be funded when Congress passes the department's budget for that fiscal year. Non-recurring maintenance SCIP projects-repairs and renovations within the existing square footage of a facility that total more than \$25,000-are available for funding on the first day of the fiscal year for that project's submission because they have advance appropriations.

An official from the office that oversees SCIP told us that the timing of the budgeting process, which is outside VA's control, contributes to these delays. While these aspects are outside of its control, VA has chosen to wait about 6 to 10 months to report the results of the SCIP scoring process to the medical facilities. This situation makes it difficult for local officials to understand the likelihood that their projects will receive funding. A VA official said that for future SCIP cycles, VA plans to release the scoring results for minor construction and non-recurring maintenance projects to local officials earlier in the process. At the time of our review, however, the official did not have a timeframe for when VA would do this. Although VA acknowledges many of these limitations, it has taken little action in response. Federal standards for internal control state that agencies should evaluate and determine appropriate corrective action for identified limitations on a timely basis.<sup>7</sup> If VA does not address known limitations with the SCIP process, it will not have reasonable assurance that SCIP can be used to accurately identify the capital necessary to address its service and infrastructure gaps. In our April 2017 report, we recommended that VA address identified limitations to the SCIP process, including limitations to scoring and approval, and access to information. VA partially concurred, noting that it generally concurred with the recommendation to address limitations in the SCIP process, but limited its concurrence to addressing the limitations that are within its control.

#### VAIP Process

The VAIP process produces a market-level health services delivery plan for each Veterans Integrated Service Network (VISN) and a facility master plan for each

<sup>7</sup> See GAO 14 704G.

medical facility—which VA has estimated to cost \$108 million when fully complete.<sup>8</sup> However, the VAIP process’s facility master plans assume all future growth in services will be provided directly through VA facilities. This assumption is not accurate given that VA obligated about \$10.1 billion to purchase care from non-VA providers in fiscal year 2015. VA can provide care directly through its medical facilities or purchase health care services from non-VA providers through both the Non-VA Medical Care Program (referred to as “care in the community” by VA) and clinical contracts.<sup>9</sup>

The Office of Management and Budget’s acquisition guidance notes that investments in major capital assets should be made only if no alternative private sector source can support the function at a lower cost.<sup>10</sup> This consideration is particularly relevant as VA’s data projects that the number of enrolled veterans will begin to fall after 2024. Officials who oversee the VAIP process said that they were still awaiting other VA offices to complete analyses required by recently released VA guidance, but as a result of this and other limitations, some local VA officials said that they already bypass the VAIP process and contract for their own facility master plans. In our April 2017 report, we recommended that VA assess the value of the VAIP’s facility master plans as a facility-planning tool, and based on conclusions from the review, either (1) discontinue the development of VAIP’s facility master plans or (2) address the limitations of VAIP’s facility master plans. VA concurred with the recommendation and noted that all future VAIP facility master plans will embrace all recent and evolving guidance, especially regarding care in the community opportunities.

#### **VA Has Faced Challenges When Not Fully Engaging Stakeholders in Its Facility Alignment Efforts**

VA has encountered challenges to its facility alignment efforts, in part, because it has not consistently followed best practices for effectively engaging stakeholders. VA may align its facilities to meet veterans’ needs by expanding or consolidating facilities or services. Stakeholders—including veterans; local, state, and federal officials; Veterans Service Organizations; historic preservation groups; VA staff; and Congress—often view changes as working against their interests or those of their constituents, especially when services are eliminated or shifted from one location to another.

We have previously identified best practices for stakeholder engagement in facility consolidation actions, recommending that stakeholder outreach begin well in advance of any facility changes and developing a two-way communication strategy to address concerns and explain the data, the rationale, and the overarching benefits behind decisions.<sup>11</sup> Failure to effectively engage with stakeholders about alignment changes can undermine or derail facility alignment. We found that VA has not consistently engaged stakeholders, and, in some cases, this resulted in adversarial relationships that reduced VA’s ability to better align facilities with the needs of the veteran population. In other cases, we observed two-way communication with stakeholders that resulted in more productive relationships and effective alignment efforts, such as with a medical facility that successfully closed an underutilized inpatient wing, closed a leased community based outpatient clinic, and relocated a domiciliary.

This inconsistency in communication practices may result, in part, from a lack of VA guidance for incorporating best practices into stakeholder communication. Fur-

<sup>8</sup> VA organizes its system of care into regional networks (VISNs), which are responsible for coordination and oversight of all administrative and clinical activities within its specified geographic region. As of January 2017, VA officials told us they had mostly completed the VAIP process in 6 of the 18 VISNs and had plans to start or complete the remaining VISNs by October 2018.

<sup>9</sup> VA uses the services of non-VA providers in non-VA facilities under the following statutory authorities: 38 U.S.C. §§ 1703, 1725, 1728, 8111, and 8153. The Non-VA Medical Care Program includes the Choice Program and Patient-Centered Community Care. The Choice Program was authorized under the Veterans Access, Choice, and Accountability Act of 2014 (Choice Act), which appropriated \$10 billion for the furnishing of non-VA care when veterans’ access to VA health care does not meet applicable timeliness or travel requirements. Pub. L. No. 113–146, 128 Stat. 1754 (2014). VA may authorize Choice Program care until such funds are exhausted. Pub. L. No. 115–26, § 1, 131 Stat. 129 (2017). Patient-Centered Community Care is a nationwide program where VA may authorize non-VA care when a VA facility is unable to provide certain specialty care services, such as cardiology or orthopedics, or under other conditions. To implement the program, VA utilizes two contractors, Health Net and TriWest, to establish networks of providers in a number of specialties—including primary care, inpatient specialty care, and mental health care.

<sup>10</sup> See Office of Management and Budget, Circular No. A–11.

<sup>11</sup> See GAO 12 542.

ther, VA officials stated that they do not monitor and evaluate their communication methods for effectiveness in reaching their intended audiences. This runs counter to federal standards for internal control, which note that agencies should monitor and evaluate their activities.<sup>12</sup> Without guidance that adheres to best practices for fully integrating stakeholders and without monitoring and evaluation of this process, VA does not have reasonable assurance that its staff are meaningfully or effectively engaging stakeholders in the capital alignment decisions that affect them. In our April 2017 report, we recommended that VA (1) develop and distribute guidance for VISNs and facilities using best practices on how to effectively communicate with stakeholders about alignment change, and (2) develop and implement a mechanism to evaluate VISN and facility communication efforts with stakeholders to ensure that these communication efforts are working as intended and align with guidance and best practices. VA concurred with our recommendations and outlined a plan to implement these recommendations.

Chairman Roe, Ranking Member Walz, and Members of the Committee, this concludes my prepared statement. I am happy to answer any questions related to our work on VA's efforts to align its medical facilities and services.

#### **GAO Contact and Staff Acknowledgments**

If you or your staff members have any questions concerning this testimony, please contact me at (202) 512-7114 or [draperd@gao.gov](mailto:draperd@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Other individuals who made key contributions to this testimony include Dave Wise, Director; Keith Cunningham, Assistant Director; Jacquelyn Hamilton; Jeff Mayhew; Malika Rice, Michelle Weathers; and Crystal Wesco.

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### **Prepared Statement of James M. Sullivan**

Thank you, Chairman Roe, Ranking Member Walz, and Members of the Committee, for the opportunity to appear today to discuss the Department of Veterans Affairs (VA) capital asset program and address VA's responses to the findings in the Commission on Care report, the Independent Assessment, and Government Accountability Office (GAO) Report 17-349 "VA REAL PROPERTY - VA Should Improve its Efforts to Align Facilities with Veterans' Needs." Additionally, I would like to discuss VA's ongoing efforts to dispose or reuse vacant buildings and the need for additional tools that will provide extended opportunities to reduce VA's portfolio of vacant assets.

#### **VA Real Property Portfolio**

VA's mission is distinct from other Federal agencies, in that we operate the nation's largest integrated healthcare system, with more than 1,700 health service delivery sites, including hospitals, clinics, community living centers, domiciliaries, residential rehabilitation sites, and other types of facilities. Additionally, VA administers a variety of benefits and services, and operates 135 national cemeteries nationwide.

The Department owns and leases real property in hundreds of communities across the U.S., and overseas. Overall, VA maintains approximately 155 million square feet (SF) in 6,274 owned buildings, and more than 35,000 acres of land. Approximately 24.6 million SF of space has been acquired through over 1,926 leases for the Department. VA's portfolio of nearly 180 million SF is one of the largest in the Federal Government and is unlike many Federal agencies; VA owns the majority of its portfolio - 86 percent of its square footage - which means real estate plays an important role in our overall asset management. Another aspect that separates VA from other Federal agencies is the fact that the average age of a VA owned building is approaching 60 years old. Managing a portfolio of that size and age is complex, takes a significant amount of resources, and requires a great deal of flexibility to both modernize and adjust to changing demographics of the Veteran population.

#### **VA's Capital Asset Needs**

Most of the VA's infrastructure portfolio is dated, in need of repair/replacement, and requires considerable investment. The need is exacerbated because the majority of VA facilities have out-lived their useful life-cycle. VA has more than \$50 billion in capital needs, identified through VA's Strategic Capital Investment Planning (SCIP) process, over the next 10 years to modernize and maintain its infrastructure. Specifically, VA's fiscal year (FY) 2018 budget requests \$512 million for major construction, \$342 million for minor construction, \$1.9 billion for non-recurring maintenance and \$954 million in medical facilities funds for VA real property leases. VA's FY 2018 request reflects VA's commitment to modernize and fix its existing infrastructure by directing significant resources to projects that correct critical building and infrastructure deficiencies that are in need of repair. VA will also need flexibility to repurpose some facilities and develop partnerships or joint ventures with academic affiliates, the Department of Defense, and the private sector where appropriate. This flexibility will allow VA to assure both access and quality of care, and even expand access to care for Veterans in some markets.



### **VA Real Property Disposal**

One of Secretary Shulkin's top five priorities is "Modernizing (VA) Systems" which includes focusing on infrastructure improvements and streamlining. In support of this priority, VA has identified 430 individual vacant buildings totaling 5.9 million gross SF that are geographically dispersed through VA campuses nationwide. On June 20, 2017, the Secretary announced VA's plans to initiate disposal through demolition, sale or transfer; or reuse actions for these vacant buildings totaling 5.9 million square feet, over the next 24 months. These buildings are not being used to serve Veterans, and the \$7 million in annual capital and operating expenses currently used to maintain these vacant buildings can be better utilized to serve Veterans.

VA evaluated the 430 vacant buildings and categorized them for disposal based on data regarding several factors. These factors included whether the buildings were classified as historic or historic eligible, had environmental concerns, or if there were more complex issues preventing disposal or reuse of the buildings. VA welcomes support from Congress to streamline approval timelines and processes in order for VA to better align owned assets and make business decisions without undue statutory or regulatory constraints from environmental and historic preservation stakeholders who might unintentionally negatively impact cost effective disposal or reuse actions, while still maintaining good environmental outcomes. On June 20, 2017, Secretary Shulkin also announced that VA will review another 784 non-vacant, but underutilized buildings to determine if additional efficiencies can be identified to be reinvested in veterans' services. This effort will be incorporated as the Department works towards the goal of high performing healthcare networks

### **Available Outleasing Tools**

VA has made progress in its efforts to reduce its vacant building footprint, and is continuing to aggressively pursue reuse and disposal strategies. Since 2004, VA has disposed or reused 1,059 assets totaling approximately 8.3 million gross SF and 932 acres. One of VA's most successful real property asset management tools is its Enhanced-Use Lease (EUL) authority. The EUL authority currently allows VA to outlease assets to private and public sector entities, and to transform vacant buildings into housing for homeless Veterans, at little or no long-term carrying cost to VA. The program has provided significant benefits to VA in terms of annual cost savings; improved facilities consistent with VA's mission and operations; increased healthcare services; substantial private investment in VA's capital facilities and infrastructure; creation of jobs; and increased tax revenues for local communities.

VA is one of the few Federal agencies with an EUL authority, and VA manages one of the most successful versions of these programs within the Federal Government. Approximately 4.5 million SF of VA building space has been outleased in public-private partnerships through VA's EUL authority. This has resulted in over 2,700 operational housing units for homeless Veterans, Veterans that are at-risk for homelessness, and in some situations, their families.

VA previously had broader EUL authority that allowed for mixed-use and other wide-ranging partnerships beyond supportive housing. Such uses were consistent with VA's mission and operations. While that authority lapsed in December 2011, VA has submitted draft legislation to Congress that proposes to expand the EUL authority beyond the scope of supportive housing. This would allow greater reuse flexibility of unneeded assets, and to improve services for Veterans.

Additionally, VA is embarking on a program authorized through the National Historic Preservation Act (NHPA) for Historic Outleasing and Exchange Actions that allows expanded ability for reuse of historic properties beyond housing.

### **Public-Private Partnerships**

In addition to utilizing the EUL program, VA welcomes opportunities to explore other forms of public-private partnerships that can provide additional tools to supplement VA's capital requirements and offer new methods to enhance the facilities used to serve Veterans and their families. VA could utilize additional public-private partnerships opportunities to support the right-sizing and adaptation of VA's owned infrastructure. Further flexibility to engage potential partnerships to renovate or reuse existing facilities could provide VA with cost savings upfront and help support improved services for Veterans.

### **Choice Act - Independent Assessment**

The Independent Assessment Recommendations related to facilities (Section K) focused on VA capital project selection/project portfolio; capital project delivery; utilization of existing infrastructure; and the use of transformative options to address

unfunded capital requirements. In response to language in the Fiscal Year 2017 Appropriations Bill requiring a National Realignment Strategy, VA began efforts to conduct objective assessments of the markets within the VA healthcare system.

#### **Commission on Care**

VA agreed that the Commission on Care's recommendation on facilities was critical to enabling a successful transformation of VA's healthcare system to a modern high-performing integrated network to better serve the needs of Veterans now and in the future. VA stated that a strong suite of capital planning programs, tools, resources, modernized facilities where appropriate, and proper dispositioning of outdated facilities, consistent with the Commission's recommendations, would be needed to fully realize the benefits and Veteran outcomes expected from implementing an integrated healthcare network. Specifically, VA agreed with the Commission that it is critical for VA to determine the optimal mix of healthcare services to meet Veterans needs at the market level before realigning its infrastructure in concert with partner resources in the market. VA also agreed that greater statutory authority and tools are needed to address the Department's real property needs and realign VA's capital assets, including divestiture of outdated properties where appropriate.

#### **GAO Report 17-349 - VA REAL PROPERTY**

The report highlighted GAO's findings related to VA's SCIP process, the VA Integrated Planning (VAIP) process, and VA's stakeholder communication efforts related to facility alignment decisions. In response to GAO's report, VA partially concurred with the recommendation regarding the SCIP process, and agreed to address the limitations that are within VA's control. Many of the items noted by GAO are found outside of the SCIP program's purview, in areas where VA has limited ability to influence changes. The SCIP process is a data-driven, long-range planning tool that integrates all capital investment needs across VA. SCIP informs investment and annual budget decisions by annually setting capital investment policy direction and project priorities, but it is not a budget tool. It does not guarantee whether or when necessary levels of funding will be received or otherwise made available.

To the extent possible, VA is implementing changes to the SCIP process to support better access to project data, improve the visibility and prioritization of sequenced projects, minimize administrative burdens, rationalize proposals based on the realities of Veteran Choice and shifting demographics, and to improve communication of SCIP results to VA planners as early as possible in the process. This also includes reducing the administrative burden of providing SCIP documents.

Through the VAIP process, an estimated 60 Facility Master Plans (FMP) were completed on a Veterans Integrated Service Network (VISN) basis following development of Service Delivery Plans. These FMPs provided a guide for planning and development over a 10-year period. The FMPs were considered highly valuable at the time of inception. VA has considered the feedback from GAO's report and in support of emphasis on Care in the Community, there will be a strategic pause in the VAIP process. VA is in the process of reassessing facility needs as a consequence of the assessment of local health systems during the market based health system optimization process. VA will evaluate service delivery opportunities in each market to build local high-performing integrated healthcare networks.

GAO also stated that VA needs to enhance communication with stakeholders. To ensure consistency in stakeholder engagement efforts and address GAO's recommendations, the Veterans Health Administration's (VHA) Office of Communications is developing a standard operating procedure (SOP) for all VISN and facility public affairs officers to follow when there is a change in mission and/or realignment. The SOP directs that VHA use the template communications plan, including timeline for notifications, target audiences, and example key messaging. In addition, the SOP provides guidance for facilities to implement evaluation tools to measure the return on their communications investment in sharing information with stakeholders, including after action reports, media monitoring tools, and direct feedback from target audiences. The VHA Deputy Under Secretary for Health for Operations and Management disseminated the SOP through a memorandum to facility and VISN leadership on June 30, 2017, and the topic will be discussed on Network Director monthly conference calls and facility leadership calls, providing an opportunity for discussion and questions. VHA has also established a mechanism for sharing best practices.

#### **Way Forward - High Performing Healthcare Networks**

VA is working collaboratively to address the Independent Assessment Recommendations, the Commission on Care's recommendation on facilities, and GAO Report 17-349. VA is working towards the goal of high performing healthcare net-

works that take into account current and future Veteran demand for medical care, and responsive services by integrating community care, telehealth services and VA-provided healthcare. VA is partnering with private sector healthcare experts to conduct objective assessments and develop local health system optimization plans.

The assessment methodology was developed between the VHA Office of Policy and Planning, VHA Clinical Operations and the VHA Office of Community Care. The assessment methodology was subsequently tested in three pilot markets between April and July 2017. An acquisition process is underway to select a contractor to assist VA with using the pilot results to create a final methodology for use beginning in September 2017 to assess and recommend health system optimization in all 96 markets of the VA healthcare system by the first quarter of FY 2019.

The primary outcomes of the assessments will be a plan for each market to develop a high performing healthcare network. Creating a high performing network will include an evaluation and potential use assessment of all market capabilities including VA, Department of Defense (DoD), Academic Affiliates, Federally Qualified Health Centers, and other community providers. Once the market assessment is complete, recommendations may include capital investments, divestments, leasing, public-private partnerships, and other approaches for modernizing VA services and infrastructure. In addition to the capital component, the plan will include programmatic/service-line recommendations, as well as opportunities to increase capacity from process improvement and integration of telehealth services.

VA expects that these market area optimization plans will address the Independent Assessment, the Commission on Care recommendations, and GAO concerns by balancing demand for and supply of services in each local market by using government partners, academic affiliates, and private sector resources to provide Veterans improved access, excellent quality care, and greater satisfaction. In addition, the plans will encourage cost effective strategies for coordinating all aspects of a high performing healthcare network while eliminating duplicative and inefficient processes.

#### **Support from Congress**

In order to build upon VA's success, continued support from Congress is needed. As the Secretary stated at his recent FY 2018 budget hearings, VA's budget submission includes proposed legislative requests that, if enacted, would increase the Department's flexibility to meet its capital needs. VA included proposals to: (1) increase from \$10 million to \$20 million the dollar threshold for minor construction projects; (2) modify title 38 to eliminate statutory impediments to acquiring joint facility projects with DoD and other Federal agencies; and (3) expand VA's EUL authority beyond supportive housing. VA is also seeking Congressional authorization of 27 major medical leases in order to establish new points of care, expand sites of care, replace expiring leases, and expand VA's research capabilities. The majority of these leases have been included in previous budget requests, some dating back to the FY 2015 budget submission.

#### **Conclusion**

VA has a complex real estate portfolio, and seeks to maintain the optimal mix of assets needed to provide high quality care, readily accessible services, and outstanding benefits to our Nation's Veterans. VA welcomes new or expanded tools and the necessary flexibilities to address its infrastructure needs and reduce vacant real property assets, including establishing viable reuses where possible and saving taxpayer dollars. The Department will keep the Committee informed as progress is made on healthcare market assessments.

Mr. Chairman, Ranking Member, and Members of the Committee, this concludes my statement. Thank you for the opportunity to testify before the Committee today. I would be happy to respond to any questions you may have.

