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**STATEMENT OF
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BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
OCTOBER 12, 2017**

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

On behalf of DAV (Disabled American Veterans) I am pleased to present our views on draft legislation, the *Asset and Infrastructure Review Act of 2017*, as well as H.R. 2773, regarding the sale of Pershing Hall. As you know, DAV is a non-profit veterans' service organization comprised of 1.3 million wartime service-disabled veterans dedicated to a single purpose: empowering veterans to lead high-quality lives with respect and dignity. To help fulfill the promises to the men and women who served, DAV advocates for sufficient resources for the Department of Veterans Affairs (VA) health care system to include funding for and adequate staffing levels and well-maintained, modern infrastructure to deliver timely, comprehensive, high-quality care to enrolled veterans.

As the Committee and Congress are aware, the last several years have been tumultuous for the VA health care system—but they have also resulted in historic opportunities for needed reforms. Following revelations of the waiting list scandals and access crisis in the spring of 2014, Congress responded by enacting legislation, the *Veterans Access, Choice and Accountability Act (VACAA)*, creating the temporary veterans Choice program, which the Committee is currently working to revise and reauthorize this year. DAV and other veterans service organizations (VSOs) supported the temporary Choice program to rapidly address access issues, while also working towards long-term reforms and solutions to expand access and improve health care outcomes.

Together with our partners in *The Independent Budget (IB)*—Paralyzed Veterans of America (PVA) and Veterans of Foreign Wars (VFW)—we developed a Framework for Veterans Health Care Reform in November 2015. We recommended the development of integrated networks that combine the best of VA and community providers to ensure continuous and timely access to care for all enrolled veterans. The IB Framework also included the following recommendations regarding VA's infrastructure:

“To better align medical care and services with where veterans need that care, the IB’s framework would require VA to reassess all currently proposed and future major construction projects and find ways to leverage community resources to identify private capital for public-private partnerships (P3) as an alternative and more efficient manner to build and maintain VA health care facilities. This would enable VA to invest in services the community lacks, while ensuring it continues to provide specialty care, such as mental health and spinal cord injury/disease care, in state-of-the-art facilities. Future capital infrastructure expansion would be based on need and demand capacity assessments, which would incorporate the availability of local resources.”

DAV and our IB partners have advocated for years to resolve VA’s many infrastructure challenges, particularly inadequate funding, inefficient construction programs, ineffective sharing authorities and inflexible leasing authorities. We have consistently argued that VA must have the ability to build, buy, lease or share health care facilities when and where veterans require them, as well as the flexibility to construct, modernize, realign, consolidate or close facilities as veterans’ needs and preferences change. Most critically, VA must be provided sufficient funding to maintain, realign and modernize its health care facilities—yet for more than a decade the actual appropriations for VA’s Major and Minor Construction accounts has been woefully inadequate.

The first finding of the Independent Assessment mandated by VACAA was that the root cause of VA’s access problems was a “...*misalignment of demand with available resources both overall and locally...*” leading to the conclusion that “...*increases in both resources and the productivity of resources will be necessary to meet increases in demand for health care...*” in the future. Specifically, the Independent Assessment found that the, “... *capital requirement for VHA to maintain facilities and meet projected growth needs over the next decade is **two to three times higher** [emphasis added] than anticipated funding levels, and the gap between capital need and resources could continue to widen.*” Without change, the estimated gap will be between \$26 and \$36 billion over the next decade. For fiscal year (FY) 2018, DAV and our IB partners recommended over \$2.5 billion for all VA infrastructure programs; however, the Administration requested only \$990 million. Unless this trend is reversed, no VA health care or infrastructure reforms can be successful.

However, it is neither feasible nor advisable to address infrastructure issues in isolation from the many other factors involved in reforming the delivery of veterans’ health care. As both the Independent Assessment and the Commission on Care report from June 2016 concluded, real transformation of the VA health care system will require an “integrated systems approach.” They recommended that reforms necessary in each aspect or domain of VA health care be integrated into an overall plan that considers how changes to one part of the system affect the whole system. As such, Congress should not consider systemic changes to VA’s health care infrastructure separately without first determining how, when and where VA will deliver health care services to enrolled veterans.

In fact, last week the Committee conducted a roundtable discussion on draft legislation to authorize a replacement veterans' Choice program that would create a new model of health care delivery integrating community providers into VA networks to fill gaps in access, similar to the IB Framework proposals. The Senate and VA are also working on similar plans and legislation to reform how VA delivers care. Those efforts should be merged with efforts to reform VA's infrastructure in a plan that is cohesive and that overlaps. For example, the draft infrastructure bill under consideration today calls for a one-time capacity and market assessment whereas the draft choice bill calls for annual assessments. Further, decisions about how to structure integrated networks to achieve the optimal balance between VA and community providers are both based on and will help determine necessary changes to VA's existing health care infrastructure. Given the overarching goals of VA health care reform, it is impossible to separate how health care is delivered from where it is delivered. Therefore, DAV recommends that the two draft bills – one to reform VA infrastructure and the other to revise the choice program – be merged into a single bill focused on comprehensive reform of the VA health care system.

Furthermore, to ensure the long-term success of VA health care and infrastructure reforms, Congress must also address other interrelated challenges facing the Department. In addition to adequate and timely resources, VA needs to improve its HR policies to recruit, hire and retain high-quality personnel, particularly clinicians, as well as modernize its IT systems, including the new electronic health care record system. Without adequate resources to sustain these critical changes and meet all its statutory missions, no legislative reforms will be fully successful.

Mr. Chairman, while we share your intention of providing VA with greater control over its infrastructure, there are important changes and improvements that need to be made to the legislation to achieve that goal.

As currently drafted, the *Asset and Infrastructure Review Act of 2017*, has the same framework as the *Defense Base Closure and Realignment Act of 1990*, legislation enacted to facilitate the closure of military installations. Although both involve changes to physical infrastructure, there are significant differences between the two departments. For example, the Department of Defense (DOD) has tremendous flexibility in planning facility locations since military personnel can be ordered to relocate. By contrast, VA health care decisions are driven by the needs of local veteran populations and veterans cannot be compelled to relocate. In a military BRAC (base realignment and closure), the most affected stakeholders are local communities who benefit from the level of economic activity generated by the presence of a military installation. Decisions to close military bases in some communities often result in a significant negative economic impact to businesses and workers. When VA closes a medical facility, the most affected stakeholders are veterans who rely on the system for some or all their medical care. Decisions about how and where to deliver medical care should never result in veterans losing access to care. Additionally, a military BRAC involves national security issues and classified data, justifying a need for secrecy, but a VA facility review has no

similar justification for limiting the ability of veterans and the public to have full access to all data and deliberations.

For these and other reasons, the military BRAC process was designed to be closed, non-transparent and inflexible to limit the engagement and influence of public stakeholders. While this approach may be necessary in the context of closing military bases, both for national security and political reasons, it would be inappropriate and counterproductive in trying to reform the delivery of veterans' health care.

The draft legislation under consideration establishes a very specific asset and infrastructure review process modeled closely on the BRAC process. The legislation establishes a multi-tiered approval procedure that includes the VA Secretary, an independent Commission, the President and Congress. First, the Secretary would propose both the criteria to be used for making recommendations to modernize, realign, consolidate or close VA facilities, and subsequently would propose a comprehensive list of facility changes. Next, an independent Commission comprised of 11 individuals appointed by the President, after consultation with Congress, would review the recommendations using the criteria previously established. Based on its independent judgement, and with limited public input, the Commission would either approve and forward to the President the full list of recommendations, or would modify, approve and forward a revised list of recommendations. Next, the President would either approve the full list and forward it to Congress, or he would disapprove in whole or in part the recommendations and return them to the Commission. If returned, the Commission would then reconsider and make revised recommendations to the President, who would either approve and forward to Congress, or by direct action or inaction, disapprove the recommendations, which would end the entire process at that point.

Finally, if recommendations are approved by the President, Congress would have 45 days to pass a motion of disapproval of the entire list of facility recommendations, otherwise it would be implemented. Throughout this multistep review process, there are limited opportunities for stakeholder and public review and input, and the entire process would take less than two years.

Mr. Chairman, we have significant concerns about the flexibility and timing of the asset review process as currently written in the draft legislation. The legislation requires that there be a single, comprehensive list of recommendations for all VA facility closings, realignments, consolidations or modernizations—essentially an all-or-nothing proposition. While such inflexibility may have been necessary for extremely difficult and politically sensitive base closure decisions, it creates more problems than it might resolve for VA health care infrastructure decision-making. For example, what happens in the years following the completion of this asset review process if unexpected veteran migration results in changes in the level of demand for care in certain communities, or if community partners disengage from VA partnerships due financial or business reasons? Would VA need to re-establish another comprehensive asset review process to make additional facility decisions?

Given the rapidly changing nature of medicine and the unpredictable market dynamics in the American health care landscape, we believe it is essential that VA have the flexibility to quickly adjust and respond to market changes to avoid negatively impacting enrolled veterans. Rather than a comprehensive, all-or-nothing, one-time infrastructure review process, VA needs to have the authority and flexibility to make decisions through an iterative process as demand for care and market conditions continue to evolve over time. Specifically, we recommend that facility recommendations by the Secretary be done in phases, with the first phase consisting of buildings and properties that are currently unused or significantly underused. The second phase, and all additional phases, should be conducted following the completion of capacity and market assessments, which should be conducted every couple of years, when and where warranted. A phased approach will allow VA to quickly eliminate unnecessary facilities and their associated costs, while ensuring a more deliberative, flexible and iterative process that allows VA's infrastructure to expand or contract as required in each individual market across the country.

DAV also has significant concerns about the timing and duration of the various reviews and approvals delineated in the current draft legislation. As discussed above, decisions regarding infrastructure should be made **after** decisions are confirmed regarding how, where and who will deliver health care in the future, including the development of new regional integrated networks and decisions about the role of community care. Therefore, the first stage in the asset review process—establishing criteria for infrastructure changes—should not begin until **after** decisions have been finalized regarding the arrangement of regional integrated networks and community care. Second, we recommend that the time allotted to the Secretary for proposing criteria be extended to no less than six months to allow sufficient time for public and stakeholder input, including due consideration of that input, with at least an additional 90 days allotted for public comment and review before publishing final criteria. Third, we recommend that if the asset review process results in an adopted set of recommendations for facility changes, the Secretary be required to certify to Congress that he has secured the necessary funding, authorities and agreements with appropriate community partners, before initiating any actions to close, consolidate or realign existing facilities currently delivering care to veterans. The Secretary should also be required to certify that no enrolled veterans will lose access to health care due to the enactment of these recommendations. In addition, the definition of “modernize” should be amended to specifically include the “construction, purchase, lease or sharing of facilities.”

Mr. Chairman, DAV is equally concerned about the lack of openness and transparency in the proposed asset review process. By using the BRAC statute as the starting point for this draft legislation, the bill inherited a very closed process regarding information sharing and deliberations. For example, although the bill requires that meetings of the Commission be open to the public, the legislation specifies that “proceedings, information and deliberations” of the Commission only be made available, upon request, to a very limited number of members of relevant committees of the House and Senate. While there may have been national security reasons for including such limits during a military BRAC process, there should be no such concerns for VA facility

decisions. Therefore, we recommend that the bill be amended so that whenever decisions, reports or other information is transmitted or made available to the Commission, Congress or the President, it should also be made available to the public at the same time.

Finally, and perhaps most importantly, DAV is concerned about the lack of stakeholder engagement throughout the entire asset review process, another adverse consequence of modeling the bill on the BRAC statute. It is critical that stakeholders who will be most affected by the outcomes of this asset review process be fully engaged from the beginning. Not only will this result in a better set of decisions, it will also help build the support and confidence necessary to enact and enforce the recommendations and outcomes of the asset review process. Some may recall that another facility review process from 15 years earlier—VA CARES (Capital Asset Realignment for Enhanced Services)—was met with opposition and was largely ineffective in part due to the lack of early and frequent engagement with local veterans from impacted communities and national VSOs.

As demonstrated by recent successful reforms related to appeals modernization, the forever GI Bill and accountability legislation, engaging stakeholders early and often is essential to successfully enacting meaningful reforms. Therefore, DAV recommends that the draft legislation be amended to:

- Require the Secretary to consult with VSO stakeholders before proposing criteria for the asset review process;
- Require that veteran preferences for receiving health care be included among the criteria proposed;
- Require the Secretary to consult with VSO stakeholders, including local veterans in each regional market, during the capacity and market assessments;
- Require that market assessments consider the unique ability of federal health care to retain a presence in rural areas where commercial providers may not exist or are at risk of leaving;
- Require that market assessments consider how deficiencies may be filled by expanding VA capacity through extended hours of operation, increasing personnel or expanding treatment space through construction, leasing or sharing of health care facilities;
- Require the Secretary to consult with VSO stakeholders before making facility recommendations;
- Require the Secretary, as part of the justification for the facility recommendations, to also include information that:
 - Details how and where enrolled veterans will receive care following facility changes;
 - Identifies the resources and authorities necessary to achieve the recommended facility changes; and
 - Identifies any non-VA partners who will provide care to veterans once facility changes are made, including contingency plans should VA fail to reach agreement with appropriate partners;

- Require the Commission to hold hearings in all regions where closings, consolidations or realignments are proposed by the Secretary or the Commission;
- Revise the language requiring each public hearing of the Commission to include “a veteran” to instead require “open public hearings that allow as many witnesses as possible to testify before the Commission, with preference provided to current users of VA health care in that region;” and
- Remove the language requiring witnesses to testify under oath, a requirement that does not exist for witnesses at most Congressional hearings.

Finally, DAV believes that any Commission created to review the future of VA health care facilities must first and foremost represent the interests of the users of that system. Currently, the draft legislation would only require that three members of the Commission be veterans. We recommend that the draft legislation be amended so that the President is required to “consult with congressionally-chartered, membership and resolution-based veterans service organizations concerning the appointment of three members” and that the Commission be required to include “at least six members who are currently enrolled in and have used the VA health care system during the preceding year.”

Mr. Chairman, although we have significant concerns with and substantial recommended changes to the draft legislation, we share the overall goal of modernizing, realigning and right-sizing VA’s health care infrastructure so that it can deliver timely, high-quality care to our nation’s ill and injured veterans. We understand that this will require difficult decisions about facilities in some locations; however, we are convinced that the only way to succeed in this endeavor is with a process that is flexible, open, transparent and fully engages veteran patients and stakeholders. We are committed to working with you and the Committee to achieve our shared goals of reforming, modernizing and sustaining the VA health care system so that it can continue to meet the needs of enrolled veterans far into the future.

H.R. 2773, Authorization of Sale of Pershing Hall

This legislation would amend Section 403 of the *Veterans’ Benefits Programs Improvement Act of 1991* by adding at the end a new subsection to authorize the sale of Pershing Hall in Paris, France. Pershing Hall was dedicated in 1927 to recognize the service and sacrifice of the American Expeditionary Forces and the General of the Armies General John J. Pershing. In 1935 the building was purchased by the United States government, and in 1991 it was transferred to the Department of Veterans Affairs (VA). However, since 1998 this building has been leased out to a French firm that continues to use this property as a luxury hotel.

This legislation directs that an independent assessment be conducted to ascertain the property’s fair market value and requires that the purchaser preserve the architectural details of the exterior and interior of the building. In addition, it directs the Secretary, on or before the date of sale, to transfer to the American Battle Monuments

Commission any pertinent historical property in the possession of the Department. The funds received by the Secretary pursuant to the sale of Pershing Hall would also be transferred to the American Battle Monuments Commission.

DAV does not have a resolution specific to this issue and has no formal position on the bill.

Mr. Chairman, that concludes my testimony and I would be happy to answer any questions that you or Members of the Committee may have.