DRAFT LEGISLATION, THE ASSET AND INFRASTRUCTURE REVIEW ACT OF 2017, AND H.R. 2773, TO AUTHORIZE THE SECRETARY OF VETERANS AFFAIRS TO SELL PERSHING HALL

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED FIFTEENTH CONGRESS

FIRST SESSION

THURSDAY, OCTOBER 12, 2017

Serial No. 115–34

Printed for the use of the Committee on Veterans' Affairs

Available via the World Wide Web: http://www.govinfo.gov

U.S. GOVERNMENT PUBLISHING OFFICE

31–342 WASHINGTON : 2019

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Thursday, October 12, 2017

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

The Committee met, pursuant to notice, at 10:30 a.m., in Room 334, Cannon House Office Building, Hon. David P. Roe, [Chairman of the Committee] presiding.

Present: Representatives Roe, Bilirakis, Coffman, Wenstrup, Bost, Poliquin, Dunn, Arrington, Rutherford, Higgins, Bergman, Banks, Walz, Takano, Brownley, Kuster, O'Rourke, Correa, and Esty.

OPENING STATEMENT OF DAVID P. ROE, CHAIRMAN

The CHAIRMAN. Good morning. The Committee will come to order.

I want to thank you all for joining us today for this Full Committee legislative hearing.

Before I continue, I want to tell my friends from California that hopefully we will have a vote later on today and send some resources out for the awful fires that are going on. I experienced those a year ago in Gatlinburg, in Sevier County, Tennessee, where we lost 2500 homes and 14 lives. It is astounding what is happening there.

So I just wanted to pass that along to you all that are in California, if there is any way we can help, we are willing to help. I have been down that road.

This morning we will be focusing on two pieces of legislation: the draft Asset and Infrastructure Review, or AIR Act of 2017; and H.R. 2773, a bill to authorize the sale of Pershing Hall in Paris, France.

Since Representative Coffman will be speaking shortly on H.R. 2773, which he sponsors, I will contain my comments to the draft bill that Ranking Member Walz and I have been working on together.

Exactly three months ago today, we held a Full Committee hearing to examine concerns regarding the Department of Veterans Affairs Capital Asset Program and alignment, or misalignment, as

the case may be, of the VA medical facilities and the veteran patient population.

I came to that hearing familiar with the numerous challenges VA was facing with regard to managing an increasingly unmanageable real estate portfolio. In fact, I was so aware of those challenges I had already decided that taking action to address was going to be one of my top priorities as Chairman, yet that hearing was alarming even to me as VA's own testimony noted that the majority of VA's facilities have outlived their useful life cycle.

A couple weeks ago, I traveled to Northport, New York to meet with staff at the Northport VA Medical Center. The Northport VA Medical Center is a 90-year-old facility on a sprawling medical campus that struggles with significant maintenance issues and costs, despite dozens of mothball buildings. The condition of that facility has gotten so bad that some veterans claim they can no longer seek care safely there; instead, travel from Northport to New York City to visit the VA facilities there.

After visiting Northport, I went to Canandaigua, New York to visit the Canandaigua VA Medical Center and the Veterans Crisis Line, which is housed there. The Canandaigua VA Medical Center is an 84-year-old facility that sits on a 150-acre campus in the middle of a residential neighborhood. However, the majority of veteran patients in Canandaigua's catchment area seek care to the VA community-based outpatient clinic about 30 miles away in Rochester, New York. That clinic is nearly busting at the seams from high utilization, while the Canandaigua VA Medical Center largely sits empty.

At both Northport and Canandaigua, I saw firsthand the consequences of outdated and oversized medical campuses that struggle to maintain current standards of care without significant backbending. And we wonder why the VA health care system has struggled to provide care that meets the highest access and quality standards, and that is why Ranking Member Walz and I are working together on this draft of the AIR Act.

This legislation would require the Secretary to develop criteria to access and recommend changes to VA Medical Centers. That criteria would be published on the Federal Register, subject to a 30-day public comment period, and would be required to take into account a number of factors, including access to care, the capacity of the local health care market, input from local veteran and stakeholders, and potential costs and savings.

The legislation would also establish an 11-member Asset and Infrastructure Review Commission that would use the criteria established by the Secretary and the recommendations for action made by the Secretary to develop a report containing findings and recommendations for the modernization and realignment of VA medical facilities.

Should the commission find that any of the Secretary's recommendations deviate substantially from the Secretary's criteria and a change is needed, the commission would be required to publish a notice of proposed change in the Federal Register and conduct public hearings in the local community on the proposal of changes?

Once finalized, the commission's report would be transmitted to the President and, contingent upon his approval, to the Congress. Should Congress disagree with the commission's recommendations, we would have 45 days to issue a joint resolution of disapproval. Absent that, VA would be required to begin implementing the recommendations.

This draft bill has been circulated with VA and with the VSOs, and was subject to a Full Committee roundtable in early September. Since then, I have met individually with many Members from both sides of the dais to discuss this language and the intent behind it, and how it aligns with ongoing efforts to course-correct VA's many care in the community programs.

That said, this bill is just a draft, and I understand that there are still a number of concerns and questions about it, particularly with regard to the timeline, the composition of commissioners, and the involvement of veterans and advocates. I appreciate the many thoughtful comments made in the written statements prepared for today's hearing by our VSO witnesses and I look forward to incorporate many of their suggested changes in the coming days.

I intend to also incorporate provisions in this bill prior to its introduction to increase the threshold of minor construction projects and expand enhanced use lease authority.

Both of those changes have been discussed by this Committee before and have been requested by the Administration, and have the support of the VSOs.

Yet even with those changes, it is an understatement to say that the deck is stacked against the AIR Act. This bill is bold, transformative, and controversial. Moving forward with it will require a significant amount of political courage and, let's face it, Members are not known specifically for that. That said, veterans, VSOs, and VA employees and taxpayers alike deserve more from each of us and to recognize how serious the problem before us is and to fail to act now to institute a solution.

As Ranking Member Walz wisely noted at our hearing in July, "We can no longer kick this can down the road, Coach, because time is not on our side in this battle."

And as Representative Rice said, if there is any Committee in Washington, D.C. that has the political courage to do what is necessary, it is this one. The AIR Act is necessary.

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

OPENING STATEMENT OF TIM WALZ, RANKING MEMBER

Mr. WALZ. Well, thank you, Mr. Chairman.

And to our witnesses, thank you all for being here. I do think, maybe someday looking back, this could be a very pivotal hearing. I would echo the Chairman's statements; this is bold. I have not changed my opinion that we need to address this.

I would note that there has been, and I think rightfully so, some folks commenting on the effectiveness of this Committee and the Chairman's leadership is no small part of that. Those who said we have been tackling the easy stuff, remember how appeals started, remember how accountability started, remember how Choice and

Choice reform started, and remember the GI Bill statement. Some of us are still friends after that fight, but it took a lot.

What it shows is, it shows the courage, and this is why the Members are sitting here, you came here to do this. You came here to legislate, you came here to have healthy disagreements, you came here with the confidence that we could try and find some things together, and this is a starting point.

I would like to note a few things in this. We are working side-by-side in this, but it is a journey and it is going to be a tough one. And the witnesses, you are going to come and you are going to present your testimony. You were there at the roundtables. We can do this, but it is going to have to be done in that confidence and that trust that we have done some of these other things.

So providing the Secretary the authority to support his needs to assess and ultimately realign VA is one of this Committee's top priorities. However, I do not think any of us should forget the highest of priorities within the Committee is ensuring veterans have access to receive the highest quality services, health care, and benefits.

No one disagrees with the need to modernize the VA's infrastructure and build community partners where it makes the most sense for veterans and taxpayers. I pulled out a statement I made sitting down on this corner in February of 2007 where I was calling for a quadrennial defense review to align assets and needs that it did not understand where we were going. I remember sitting there saying, we could be sitting here in 10 years in 2017 and still not have an understanding of where we are going. So I think all of us get that part. I do not think we are there yet.

As the legislation is written, I think it takes a picture, a snapshot of VA infrastructure, and to make a decision on going forward on that is going to have decades-long impact. We need more than a snapshot; we need to develop a process that VA can use to continually make decisions on an annual basis to ensure access gaps are identified and filled early.

I also think, folks, whenever we talk about this, and it is something we should always be striving for, is the belief that it is going to be a cost saver. I think the belief is based on the fact that we hear about the 1,400 vacant buildings or under-utilized buildings. Most of these are not buildings that provide care for veterans. By my count, fewer than 20 of the 1,400 buildings scheduled for disposal in fiscal year 2018 provide direct care to veterans, while more than 70 buildings are old hospital staff residences.

What is missing I think from the conversation so far is the fact that every single VISN there are significant utilization gaps in outpatient care space and there is an excess in inpatient care space. What does that mean? It means we have empty bed towers at too many facilities, but at the same veterans are waiting in line to receive modernized outpatient care. The issue deserves serious attention. I commend the Chairman and everyone here for their willingness to face this challenge.

The legislation in its current form has more work to do. While we stated this is a draft bill and a starting place, we need to start making changes to the language. Other concerns we have is the timeline, the fact that the Secretary can deliver recommendations

to the commission before the enactment of a permanent solution to consolidating community-based care is implemented.

And most concerning to me, and I say this now, I would say it in 4 years, I would say it in 8 years, is the power of the President at the end of the process. If he or she disapproves of the recommendations, the commission ends without further action. If he or she approves the recommendations, regardless of Congress or stakeholders' agreement, by simply not signing the joint resolution of disapproval the recommendations will still be enacted.

We agree, status quo is not the answer, but I have deep reservations about this if we do not have answers to earlier questions.

Mr. Chairman, I will state it again: your leadership and guidance continues to move us ahead. Your boldness in stepping through political land mines to try and solve problems is one that I admire greatly.

I ask now that we have set the plate, we have brought the people to the table, we are prepared to now start having that serious discussion about how do we put that template in place that allows a tool for VA to move forward, how do we get a quadrennial defense review or a quadrennial VA review that starts to move us there, and how is the process still with these Members in this room having more of the power to be able to move that forward.

So, Mr. Chairman, I thank you. I look forward to the testimony of our witnesses and the engagement of all Members.

The CHAIRMAN. I thank the gentleman for yielding.

And joining us on our first panel, although testifying from the dais this morning, is our friend and colleague and fellow Committee Member, the Honorable Mike Coffman of Colorado.

Mr. Coffman, you are now recognized for 5 minutes.

STATEMENT OF HONORABLE MIKE COFFMAN

Mr. COFFMAN. Thank you, Mr. Chairman.

I would like to begin by thanking you for including my bill in today's legislative hearing and thank the witnesses for their testimony.

Mr. Chairman, I think we can all agree that the VA's sole mission is to provide services to our Nation's veterans. The maintenance of a 5-star, 24-room boutique hotel, restaurant, and club in downtown Paris, France is clearly not included in that description.

Therefore, in an effort to get the VA out of the overseas hotel business and focused on its core competencies, I introduced H.R. 2773, the Sell Excess Luxury Lodging, the SELL Act, to authorize the sale of this hotel, Pershing Hall.

Pershing Hall is a building originally procured by The American Legion to serve as a memorial to our "Doughboys," who served in France during World War I. The building was transferred to the VA in 1991, and in 1998 the VA leased Pershing Hall for a 99-year period to a French firm that redeveloped the property as a luxury hotel.

In recognition of the historic aspects of Pershing Hall, H.R. 2773 requires the preservation of architectural details of the exterior and interior of the structure, and requires all property of General Pershing and the American Expeditionary Forces in France during

World War I to be transferred to the American Battle Monuments Commission.

H.R. 2773 also appropriately requires the transfer of sale proceeds to the American Battle Monuments Commission for the maintenance of cemeteries, monuments, and memorials dedicated to our men and women in uniform.

Mr. Chairman, today you will hear the concern that the fair market value will not represent the true value of the property because it is encumbered by the VA's lease agreement. Unfortunately, the reality is that the VA negotiated a bad long-term deal that significantly decreased the market value of the property. Even more reason to get the VA out of the hotel business.

To address this concern, I plan to amend my legislation to require a condition of the sale be the appraised value of the property versus the market value. So that what the market value is, we have this horribly negotiated, really below-market lease agreement that in a market value assessment will only reflect the income of the property, this lease agreement. So it would be a windfall to the lessee, who would be the only one who could purchase it, because they would say that they are not going to—that they want the lease agreement continued and so to reflect again that lower income that would reflect the market value of the property.

What we want to do, what I want to do is to change it to appraised value. An appraised value would not reflect that lease agreement.

And so there would be under two circumstances that it would be sold, certainly not guaranteed. One would be that the lessee realizes that the future appreciation of the value is significant enough that it is good to lock in the value now, lock in the appraised value now and go ahead and buy the property despite this below-market lease agreement, or it would be another buyer who would negotiate with the lessee to buy out the lease agreement contingent upon the purchase of the sale of the, the buyer of the property. Those are the both circumstances.

And so I think it would be, although I want to get the VA out of the luxury hotel management business, I think that, you know, there has to be a fair price to the taxpayers of the United States.

While Pershing Hall is probably a terrific hotel, it makes no sense that VA keeps a luxury hotel in Paris on its books. The VA needs to focus its time and resources on its core mission, taking care of our Nation's veterans.

Mr. Chairman, thank you for allowing me to testify today on behalf of this legislation and I yield back the remainder of my time.

[THE PREPARED STATEMENT OF MIKE COFFMAN APPEARS IN THE APPENDIX]

The CHAIRMAN. I thank the gentleman for yielding.

I just have one very quick question, is that when this was leased, this 99-year lease signed? And then, I guess, why in the world would you have signed a 99-year-old lease?

Mr. COFFMAN. Sir, I think we have the VA here, but I believe that it was done, let's see, in 1998, as I understand it correctly, that the lease was signed.

The CHAIRMAN. I don't think any of us are going to be around when the lease is up.

I now yield to Mr. Walz.

Mr. WALZ. Well, this one too has always been one when it comes up, it is kind of hard to wrap your mind around this.

I do note The American Legion's positions on the historic nature of this, their involvement in it. The importance of the Pershing artifacts in World War I, especially as we are in the centennial year of World War I. So I am kind of interested to hear those reports, but I appreciate the gentleman—look, I certainly have no idea why we run a hotel and a 99-year lease. I think it is probably the transition here is what we are getting after and making sure we get that right.

So I yield back.

The CHAIRMAN. I thank the gentleman for yielding.

Mr. Bilirakis, you are recognized.

Mr. BILIRAKIS. No questions.

The CHAIRMAN. Mr. Takano, you are recognized.

Mr. TAKANO. I am certainly interested as a former high school teacher, both English and social studies, about the historical significance of this building. I think World War I had enormous consequences that we are still feeling today, the high percentage of nationalism that we are experiencing around the world was certainly present during World War I, and I am wary of us erasing physical landmarks of such a consequential war. And we are 100 years away from it, but I am always mindful that we have to be constantly reminded about the history and history that gets forgotten by generations.

So I am interested to hear what The American Legion has to say about their views on this matter.

I yield back.

The CHAIRMAN. I thank the gentleman for yielding.

Mr. Coffman has already spoken. Do you have any—Dr. Wenstrup?

Mr. WENSTRUP. Nothing at this time. I yield back.

The CHAIRMAN. Ms. Brownley?

Ms. Brownley yields.

Mr. Bost?

Ms. Kuster?

Ms. KUSTER. Thank you, Mr. Chairman.

I just want to speak on behalf of H.R. 2773, a bill to authorize the sale of Pershing Hall, and join my colleague Mr. Coffman.

Last year, I accompanied Mr. Coffman to a field hearing in Aurora, in Colorado, when, as you all know, the construction of the VA hospital in Aurora led to significant cost overruns, overruns that were unacceptable to Mr. Coffman and myself and all Members of the Committee. So at that time I joined Mr. Coffman in a version of this bill last year.

While the Aurora project no longer needs the funds from the sale of Pershing Hall, it has become clear to me that the VA should not be in the business of managing properties like a luxury hotel in Paris, France. But unfortunately, as Mr. Coffman has outlined, the current lease demonstrates exactly why the VA should not be managing properties like hotels, entering into a 99-year lease with a

French hotel company in exchange for renovations. As a result, if the VA sold this property today, we would receive a small fraction of the $80 million appraised value of the property.

So consequently, I support Mr. Coffman's proposal to amend the legislation to include as the appraised value as a condition of the sale of Pershing Hall and I urge my colleagues to support his amendment in this legislation.

And I yield back.

The CHAIRMAN. I thank the gentlelady for yielding.

Mr. Poliquin, you are recognized.

Mr. POLIQUIN. We have so many problems now in this Government and the primary responsibility of the VA is to care for those that are coming back from the battlefield, we should not be in the luxury hotel business in Europe.

The CHAIRMAN. The gentleman yields back.

Mr. Correa, you are recognized—oh, Mr. O'Rourke, I'm sorry.

Okay. Dr. Dunn, you are recognized.

Mr. DUNN. Thank you, Mr. Chairman.

I wanted to understand, so I was doing a little math here, do we have about 70 years left on this lease, is that correct? About right, that is about right. And is the penalty on that to pay back the entire 70-year lease if we sell the property?

Mr. COFFMAN. Well, if you were going to breach the lease agreement, I am sure what—maybe VA could comment—clearly there is going to be a penalty as, you know, you would sort of discount, it would be a discounted rate, but that is why I think moving to the appraised value.

And so, again, it is probably the lessee that could buy it if they assume that there is going to be a lot of appreciation to the hotel and it is best to lock it in now. Or it is going to be, again, somebody who is going to negotiate a buyout of that lease agreement and then buy the property to the appraised value.

The CHAIRMAN. The gentleman yields back.

Mr. Correa, you are recognized for 5 minutes.

Mr. CORREA. Thank you, Mr. Chairman.

First of all, I want to thank you very much for your thoughts and prayers regarding our fires in California. Southern California Fire is probably within a mile or 2 of my district, some of the evacuation sites are actually in my district. My friends and neighbors, some of my staffers have been evacuated from some of those areas. And we do pray for those that have been affected and we pray that the firefighters are able to stop these fires as quickly as possible.

In reference to Mr. Coffman's bill, I just want to say I join you in supporting your bill. We should not be in the business of managing hotels, but we should be in the business of managing taxpayer resources, and it sounds like we got snookered here. It is something that is not unusual and I would say the VA has to figure out how to manage these assets like any other professional real estate management company would do.

Our job, on my opinion here, first and foremost, like has already been said, is to make sure we take care of our moral obligation to our veterans and that everything we do is for the benefit of our veterans. A lot of times in this Nation, the issue becomes resources. Where do you get the money to take care of our veterans in the

proper way? The big expense, real estate, typically, when it comes to delivering the resources. As we look at assessing these real estate assets that we have, taxpayer-owned, let's not look at just today, but look at tomorrow.

I know we had a study group here, right over there. I looked at a map and one of those maps showed some of the real estate being located in the Inland Empire, just east of where my district is. Under-utilized today, but I will tell you, that is the fastest growing region in California and probably the United States. And I guarantee you, in 20 to 30 years, if we sell those resources today, 20 to 30 years from now, we are going to be kicking ourselves and saying this is where we need to put VA resources, VA clinics that take care of our veterans.

So let's have a little bit of vision here and let's be good stewards of real estate assets that are owned by taxpayers.

If you look at life insurance companies, they invest for the long term, because when they have to sell is when those folks die, that means 20 to 30 years out they have got to have the resources to pay on those life insurance companies. We should do the same thing, which is we know veterans, we have to take care of those veterans 20, 30, 40 years out. So let's start thinking like life insurance companies, real estate investment management companies do. We are looking at a BRAC-closure kind of a plan here.

Let me tell you about El Toro Military Base in Orange County. It broke my heart when we closed it down. The Government invested $900 million upgrading that base. The next year, through the BRAC process, we decided to close it down. El Toro, 5,000 acres in the middle of Orange County, tremendous value, a great real estate play. Let me tell you, when we closed it down, we should have thought, again, what is number one? Taking care of our vets.

Let me tell you what happened recently. The veterans came together in Orange County and said we want a veteran's cemetery in Orange County, so we won't have to go so far to visit our veterans that have made the ultimate sacrifice, deceased veterans. We fought hard to get 125 acres. The City of Irvine later on reconsidered and said, you only get 25 acres. Five thousand to 125 to 25 acres. We finally got them to give us 125 acres for a veteran's cemetery.

The lesson? Once you let go of control of our government resources, they are no longer under our control.

So, again I would ask, go slow, Mr. Chairman; be methodical, be very careful, carefully weigh the benefits as to how these resources can best be used for the benefit of our veterans. And, finally, the process has to be very transparent. Let's make sure that our veterans are front and center, that they are part of the decision-making process.

Mr. Chair, I yield.

The CHAIRMAN. I thank the gentleman for yielding. I am a Methodist, so we do everything very methodical and slow.

[Laughter.]

The CHAIRMAN. So, Mr. Higgins, you are recognized for 5 minutes.

Mr. HIGGINS. Thank you, Mr. Chairman.

I concur that we agree on a bipartisan manner, and with the cooperative and respectful communications of the VSOs that we listen very carefully to as we move forward to streamline the VA and reform the expenditures of the people's Treasury. And to look carefully at these properties that are under-used, under-utilized, some of them need to go away.

Regarding the Pershing facility being operated as a hotel, the term "appraised value" is being used. This is a business being operated as a profitable business and in the sale of any business the consideration of what is referred to as blue sky is generally considered to be part of the appraised value. In other words, not just the physical structure and the assets therein, but what is the value, how much money has the thing been making? And blue sky is generally considered for 5 years as added to the value of the property.

So I would suggest that this also be a part of the formula as we consider the sale of this property. As reflective of the sale of any real estate and as some sort of a common, you know, transaction that takes place every day many, many times across the country, that the blue sky should be considered as part of the value of that property.

So that would be my only concern. I concur that we need to get out of the hotel business and it is probably a good idea to sell the property, but I would just say that we should squeeze every dime we can out of that for the betterment of the veterans that we serve.

And with that, I yield back.

The CHAIRMAN. I thank the gentleman for yielding.

Let's see, General Bergman, you are recognized for 5 minutes.

Mr. BERGMAN. Thank you, Mr. Chairman.

Jim Collins, a great author, talks about the three most important things any business that is going to become great needs to do every year: you need to fairly evaluate what it is that you are doing that you need to keep doing, you need to evaluate what you are not doing that you need to start doing, and the biggest challenge to any, any entity is to stop doing things that no longer add value to your mission, your core business mission.

So having said that, as we look at the VA and trying to help them focus their efforts on the veterans, and focus on the veterans on their future needs, without wasting very valuable and very limited resources on things that we don't need to be doing anymore, I wholly support the getting out of the Parisian hotel, boutique hotel business, because we have limited resources, limited time, limited everything to do the right thing for the veterans. So I fully support this.

I yield back.

The CHAIRMAN. I thank the gentleman for yielding.

Mr. Banks, you are recognized for 5 minutes.

The gentleman yields.

Mr. Arrington, you are recognized for 5 minutes.

Mr. ARRINGTON. Mr. Chairman, I just make a general statement that I agree with my colleagues that we need to align assets and resources according to the core mission of the VA, and we need to make sure that we are also aligning them with the demand, where there is need, just like every other organization. And if we don't do that, then we are not being good stewards of the taxpayer dollar.

And I commend you for the process; it needs to be objective, it needs to be fact-based, and we need to remove it from the politics, the parochial politics of protecting our single-Member-district-type interest, I think that is not healthy. This should be American taxpayer and American veteran first and we drive on this.

So I commend you for your leadership and I wholeheartedly support Mr. Coffman and his efforts on this regarding the Pershing hotel. I don't know why we would be in that business. So, thanks for your hard work and I support you on that.

The CHAIRMAN. I thank the gentleman for yielding.

Mr. Coffman, do you have any final comments?

Mr. COFFMAN. Yes, Mr. Chairman. On this bill to align demand with our current infrastructure and make those appropriate changes, I want to thank you for your leadership, as well as Mr. Walz on this particular issue.

And I will say, when I grew up in Aurora, Colorado, which is the heart of my district, it was a military town with three military installations in it. Two were closed, an Army and an Air Force base in successive BRACs, and as a community member I have fought that BRAC process as hard as I could. But I can tell you, the economic development that has occurred since those closures is greater than what we had received when those bases were operational relative to the economic impact on our respective community.

I yield back, Mr. Chairman.

The CHAIRMAN. I thank the gentleman for yielding.

And just one final comment before we introduce our next panel. I think Mr. Takano made some good points about not forgetting the history and the Legion made some good points when I read their testimony. So I think we need to be sensitive and aware of that, that history, I agree. I don't know how it will all work out yet, but I do think you make good points with what you said historically about what we are trying to maintain also and let's not forget what happened in World War I. So I think I will need to think through it some more.

I want to thank you, Mr. Coffman, for your testimony. And with no other questions, we will introduce our second panel.

Joining us are Joy Ilem, the National Director for the Disabled American Veterans. Welcome. Mr. Louis Celli, the Director of Veterans Affairs and Rehabilitation Division of The American Legion; Carl Blake, the Associate Executive Director for Government Relations for Paralyzed Veterans of America. Welcome. Carlos Fuentes—and I thought we were going to have to send out a search dog for you this morning when you weren't there—the Director of the National Legislative Service for the Veterans of Foreign Wars of the United States. Dave Wise, the Director of Physical Infrastructure Team for the U.S. Government Accountability Office. Dr. Regan Crump, the Assistant Deputy Under Secretary for Health for Policy and Planning, for Veterans Health Administration of U.S. Department of Veterans Affairs, who is accompanied by James Sullivan, the Director of VA's Office of Asset Enterprise Management.

Ms. Ilem, we will begin with you. You are now recognized for 5 minutes.

STATEMENT OF JOY J. ILEM

Ms. ILEM. Thank you, Chairman Roe. Ranking Member Walz, Members of the Committee, on behalf of DAV, thank you for the opportunity to testify today on the draft Asset and Infrastructure Review legislation under consideration by the Committee.

For years, DAV, along with our independent budget partners, has consistently called for resolving VA's many infrastructure challenges, including aging and outdated medical and research facilities, consistent under-funding for major and minor construction and critical maintenance needs, as well as problematic leasing and sharing authorities.

While we do not believe the BRAC-like model proposed in the draft bill is the most appropriate way to address VA's capital infrastructure needs, we do acknowledge the need for a strategic national plan and a comprehensive infrastructure review and assessment prior to modernization or realignment of the Department's medical facilities.

Rapid advancements in medicine and significant changes in the way health care is delivered today, as well as changes in veterans' needs and preferences and demographics, require a more nimble and flexible process that allows VA to make changes when necessary to ensure the delivery of high-quality health care and specialized services throughout the system. However, we do not believe Congress should consider systemic changes to VA's health care infrastructure in isolation from other critical factors. Most importantly, without first finalizing decisions on the reform of the Choice program and development of regional integrated networks that would combine VA and community care options for veterans.

The 2016 Commission on Care Report concluded and we concur, real transformation of the VA health care system will require a comprehensive and integrated systems approach.

For successful reform of the system, the Department must also address several other critical, interrelated challenges, to include modernization of its health care IT system and electronic health record; improvements in HR policies to fill staff vacancies more rapidly, steadily increasing demand for services, and existing challenges to provide veterans convenient access to care in rural communities; all of which have significant budgetary implications.

Rather than establishing a BRAC-like, one-time asset review process, we believe VA would be better served by establishing a standardized, long-term process that includes local involvement, periodic ongoing reviews, a realistic plan for upkeep and maintenance costs, and the authority for the Department to more easily make changes as demand for care and market conditions shift over time.

Mr. Chairman, my written statement includes a number of recommended changes to the bill and I will highlight just a few that we feel are most critical.

We recommend extension of the overall timeline to ensure a thorough and effective asset review process can be conducted; inclusion of provisions for early and more meaningful stakeholder input to ensure veterans understand any proposed changes and to build support; that information transmitted to the Commission, Congress or the President also be made available to the public; that facility

recommendations be carried out in several phases, first focusing on buildings and properties that are currently unused or significantly under-used, then considering market assessments and more comprehensive alignments only after decisions have been made regarding Choice reforms.

The market assessments should include options for expanding VA's internal capacity where appropriate through extended hours of operation or by increasing staff or space.

We also recommended that no VA facility should be closed until a replacement facility is opened or an arrangement with community partners has been secured and established, so that no enrolled veteran ever loses access to care.

Finally, DAV strongly believes that any commission established affecting the future of VA health care must first and foremost represent the veteran users of that system. For these reasons, we recommend the commission include at least six members who are current users of the VA health care system and that three of those members represent congressionally-chartered membership and resolution-based service organizations.

Mr. Chairman, in closing, DAV is committed to working with you and the Committee to achieving our shared goals of improving VA health care services for our Nation's ill and injured veterans.

That concludes my statement and I am happy to answer any questions you or the Committee Members may have.

[THE PREPARED STATEMENT OF MS. JOY ILEM APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you.

Mr. Celli, you are recognized now for 5 minutes.

STATEMENT OF LOUIS J. CELLI, JR.

Mr. CELLI. Well, one thing is absolutely clear, veterans deserve a 21st century health care system; a sustainable, reliable, and compassionate system that is able to meet their needs and one that veterans can be proud of.

Chairman Roe, Ranking Member Walz, and Members of this distinguished Committee, on behalf of Commander Denise H. Rohan and the millions of veterans making up the largest Veteran Service Organization in the Nation, thank you for taking on the challenge of modernizing VA's aging infrastructure.

Admittedly, this is a complicated process and one that will require a complete assessment of VA's health care delivery services and current physical capabilities. And while The American Legion applauds this Committee for addressing VA's capital needs, we want to take this opportunity to underscore what our colleagues, Members of Congress, VA, and our members recognize, VA will need a complete comprehensive health care market assessment VISN by VISN before anyone can offer a responsible assessment or recommendation on the modernizing VA's assets and infrastructure.

The draft legislation being discussed here today helps get this conversation started. And you already have our witness statement for the record, so I will just go over some of the points that we will

need to refine before The American Legion will be able to fully support this effort.

First, The American Legion is rarely a fan of congressionally-appointed Committees and this is no different. As highlighted in our written presentation, fundamentally we oppose establishing a Committee to oversee this process, but if establishing a Committee or a commission becomes a necessary concession to moving forward, I cannot stress strongly enough that The American Legion will absolutely not support a commission whereby congressionally-chartered VSOs, the most accurate representation of voices of millions and millions of veterans this Committee has access to, are not empowered to have collective veto power over what could turn into a runaway committee.

Again, specifics on how that can be achieved are detailed in the testimony you have in front of you.

Second, the Committee has wrestled with leasing health care facilities over the past several years and, as the Chairman points out, there is no better time than now to address this in this legislation. The legislation will certainly miss the mark if we fail to fix this leasing issue once and for all.

Third, while addressing the demographics of the commission, The American Legion feels strongly, as DAV does, that the commission should be a representation of the current demographic of the average VA patient today and understand what the needs are of the VA patient tomorrow will be.

Next, The American Legion sees no reason the commission should need to financially compensate the volunteer committee members. The structure of this committee calls for senior level executives and experts that oversee millions of dollars in health care infrastructure. If the reward for serving on this committee isn't serving veterans and the honor of participating in a congressionally-appointed committee that reports to Congress and the President of the United States, then perhaps we should reevaluate the selection process.

In the draft legislation, there is a prohibition against former employees of VA who are instrumentally involved in the commission's work. I don't understand why that provision is in there at all and would like to learn more about how that might be a threat to the integrity of the process.

I also want to mention that the seats assigned to congressionally-chartered Veterans Services Organizations need to forever remain assigned to the organization and not to the appointee. We have seen in the past how appointees have undermined this authority by accepting an appointment on a visionary committee, only to divorce themselves from their organization in favor of their personal opinions, leaving the VSO community without a voice in the process. It was shameful and it was unacceptable.

Finally, with regard to this bill, page 19, line 20(c) needs to change to "The Commission will recommend changes to the Committee on Veterans' Affairs of the House and Senate." The American Legion adamantly opposes granting the commission unilateral authority to change or amend the recommendations of the Secretary. That simply cannot happen under any circumstances.

With the remainder of my time, I will address the issue of Pershing Hall in Paris, France. While many Veterans Service Organizations may not have a strong opinion one way or the other regarding Pershing Hall, please understand that this property has historical value and a deeply personal meaning for The American Legion.

Nearly 100 years ago, the members of the American Expeditionary Forces of World War I came together to preserve the memories and incidents of our associations in the Great Wars. And as the 100th anniversary of our founding approaches, The American Legion is still dedicated to that mission.

The American Legion fought for the dedication of the memorial in Paris, France, in the city where The American Legion was formed, to recognize the service and sacrifices of The American Legion Expeditionary Forces and General John "Jack" Pershing. We take this very seriously.

At a minimum, we should not be able to sort out what should immediately happen with this monument today and we look forward to working with Mr. Coffman to work this out. And I just want to echo your comments and thank you for recognizing that selling this at a fire sale is the wrong thing to do.

Thank you.

[THE PREPARED STATEMENT OF LOUIS J. CELLI APPEARS IN THE APPENDIX]

The CHAIRMAN. I thank the gentleman for yielding.

Mr. Blake, you are now recognized for 5 minutes.

STATEMENT OF CARL BLAKE

Mr. BLAKE. Chairman Roe, Ranking Member Walz, Members of the Committee, on behalf of Paralyzed Veterans of America, I would like to thank you for the opportunity to testify today.

PVA has no stated position on the Pershing Hall issue, so I will limit my comments to the Asset and Infrastructure Review bill that is being considered by the Committee.

First, Mr. Chairman, I would like to thank you and Ranking Member Walz for holding the roundtable in September where we began this discussion. Many of us at this table know that this discussion actually began before that point and we appreciate you all taking the time to address this with us.

I would say we recognize this as a necessary evil. The bottom line is, I don't know anyone who was involved in BRAC, I served in the military during BRAC, who didn't think BRAC was in some form evil, and yet it is probably a necessary process. I will say that I am not sure this bill yet gets us there to the desired end. With that in mind, we don't oppose what you are trying to do and we would like to see some refinements to this legislation.

The Commission on Care recommended a BRAC process for VA. We stated then, our partners in the Independent Budget, DAV and VFW also stated then, that we don't believe that that is the right way forward, but we recognize the need to right-size the VA's infrastructure.

The Independent Budget has stated over and over again that that was necessary. I think the Secretary understands that; his list is pretty comprehensive just in terms of buildings. But I think

there are a few key problems that were identified in the legislation during the roundtable that cannot be ignored to make this better.

I think the bill ignores what was identified as the single biggest problem—or the roundtable identified the single biggest problem with this bill is it does not give the VA time. And I know that Congress has a complicated position where time is not exactly a luxury, but the experts from GAO and from the Congressional Research Service, and all of the stakeholders in the room when we had that conversation, clearly stated that DoD had at least 3 years to prepare its BRAC process, and this bill would accomplish that with VA in far less time.

And I would argue that the VA system is far more dynamic and more complex than what DoD had to deal with. All DoD had to do was say, you live here, you are stationed here, you are moving, and that is it. That is not the way that is going to work with VA and the population it serves, and I think that that cannot be overstated.

So if we are going to go down this road, that has to be foremost in our mind. Giving the VA the time to actually lay this out properly is key.

The draft legislation we are discussing right now as it relates to Choice reform has a market assessment component. And when we had the roundtable about that draft there was discussion about the bill providing for, I think, a year for those market assessments, and most people that were part of that discussion did not believe a year was really sufficient to do that level of market assessment. And the market assessments in that Choice reform bill are probably less complex than what this BRAC process would require, and yet the draft bill gives less than a year to complete the market assessment and lay everything out in the groundwork to run out the BRAC process. That is clearly something that has to be changed in this draft bill.

I think my colleague from the DAV said something along the line of developing the integrated health care network and that whole plan for community care access before we go down the BRAC road. I think we could have a reasonable debate over whether we are putting the cart before the horse or not. Some people would say, we do this first and then we know what we have to work with. I think we take the position that we should know what the VA plans to do in terms of delivering care before we then decide what its footprint is going to look like.

So I think, because we have sort of divorced Choice reform and ultimately the plan for community care from this, I think we are setting up maybe a fatal flaw in the ultimate design of this.

Lastly, my biggest concern or one of my major concerns is I was here when CARES, towards the tail end of CARES as I came to work here in Washington. And for those of us who were here during that period, CARES did a great disservice to the VA, primarily because there was a moratorium for all intents and purposes on all new major and minor construction during the CARES process. That was a couple-of-years process where nothing new got done in VA. And I could envision a scenario where that very same philosophy plays out with this bill and that is not acceptable.

I think part of the reason we are in this situation, you mentioned Northport. Now, I can't change the fact that it is 90 years old, that is a fact, but I could also argue that many of the reasons why some of these places are not modernized is because all the way back then no money was invested in their modernization while we decided what the footprint of VA was going to be under CARES, and now here we are again.

So if we are going to go down the road with BRAC—and this is BRAC, it doesn't matter whether you say it is or not, this is BRAC for VA—if we are going to go down this road, we can't then say we are not going to do anything with VA's construction until we finish this process, because that is 2 years from now and that is not acceptable.

Mr. Chairman, again, I would like to thank you for the opportunity to testify. We would be happy to take any questions that you have.

[THE PREPARED STATEMENT OF CARL BLAKE APPEARS IN THE APPENDIX]

The CHAIRMAN. I thank the gentleman for yielding.

Mr. Fuentes, you are recognized for 5 minutes.

STATEMENT OF CARLOS FUENTES

Mr. FUENTES. Chairman Roe, Ranking Member Walz, and Members of the Committee, on behalf of the men and women of the VFW and our Auxiliary, thank you for the opportunity to present our views on legislation pending before the Committee.

The VFW agrees with the intent of H.R. 2773, which would require VA to sell Pershing Hall in Paris, France. VA should not be in the hotel business, but selling Pershing Hall should be more than just simply an effort to no longer own the building.

The VFW is glad the legislation would preserve the history of Pershing Hall and the memory of the brave American servicemembers who fought in World War I. We urge the Committee to explore the option of transferring the building to the Army's Armed Forces Recreation Centers who operates hotels throughout the world before selling the building to a private entity.

The VFW also agrees with the intent of the Asset and Infrastructure Review Act of 2017, and has several recommendations to improve it.

For more than 100 years, the Government's solution to care for veterans has been to operate a network of VA facilities throughout the country. Many of these buildings must be replaced, some of them need to be disposed of, others need to be expanded, and they all need to be managed.

The VA's Strategic Capital Infrastructure Plan, or SCIP, identifies VA's current and projected gaps in access, utilization and safety. In VA's fiscal year 2018 budget request, the estimated cost of closing all these gaps was 55 to $67 billion over 10 years.

The VFW agrees that VA has an insurmountable capital infrastructure problem and a systemic realignment of VA assets may help in addressing these gaps. However, the VFW has historically opposed a BRAC-style process for VA medical facilities, because the

population VA serves is very different than the population served by or stationed in military installations.

When I was in uniform, the Marine Corps could send me where they wanted, when they wanted, and I had little to no say about it. VA, however, does not have the ability to require veterans to move from one location to the other; it has to adjust to changes in the veteran population.

The SCIP process includes plans to address unused or underutilized facilities, but the process for approving, funding, and implementing the plan is what has led to a $67 billion backlog. That is why the VFW urges the Committee to identify barriers which delay or impede the SCIP process. If those issues are not addressed, we will find ourselves in the same or worse situation in the future.

The lack of input from affected veterans has been the principal reason previous plans to close or realign VA facilities have failed. The VFW is pleased this legislation requires the proposed commission to conduct public hearings and seek input from veterans impacted by changes, yet it does not require VA to conduct such hearings when developing its plan, and the VFW believes VA's plan must include input from local veterans in order to ensure buy-in.

Past plans to close VA medical facilities have also failed because it would create access gaps to care for veterans.

In order to avoid repeating those mistakes, the VFW urges the Committee to require VA to implement proposed solutions before closing facilities or eliminating space. Simply purchasing more care from community providers is not an acceptable option. Veterans tell the VFW that they want VA to hire more doctors and build more capacity.

Through the Choice Program, we have learned that community providers are a great force-multiplier for VA, but it is not a panacea of access or quality. This legislation requires and we support identifying opportunities to fill access gaps by purchasing care, but it does not require VA to evaluate how hiring doctors or building new facilities or leasing space would correct deficiencies or fill access gaps.

The VFW also believes that revenue generated from leasing or selling existing facilities must be reinvested into expanding access to VA care for veterans.

Mr. Chairman, this concludes my remarks. I am happy to answer any questions you or the Members of the Committee may have.

[THE PREPARED STATEMENT OF CARLOS FUENTES APPEARS IN THE APPENDIX]

The CHAIRMAN. I thank the gentleman for yielding.

Mr. Wise, you are recognized for 5 minutes.

STATEMENT OF DAVE WISE

Mr. WISE. Chairman Roe, Ranking Member Walz, and Members of the Committee, we are pleased to be here today to discuss our work related to VA's efforts to align its medical facilities and services, as well as our work on DoD's BRAC process. My colleague Brian Lepore, who is GAO's expert on the BRAC process, is sitting just behind me and will be pleased to answer any questions on BRAC.

VA is one of the largest health care systems in the United States, annually providing care to nearly 9 million veterans. It is also 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 covering approximately 170 million square feet of space. A large number of its facilities are underutilized and outdated, creating a variety of challenges for alignment. Real property management overall, including VA, has been on GAO's high-risk list since 2003.

Our testimony today is based on our April 2017 report examining VA's efforts to align its facilities with veterans' needs and on numerous GAO reports related to the BRAC process as summarized in June 2011 and March 2012 testimonies. I will address two key areas today: one, the factors that affect VA facility alignment with the veteran population, and, two, the key elements and challenges affecting DoD and the 2005 BRAC Commission that could be instructive as the Committee considers the proposed legislation before it today.

As we discussed in our April 2017 report, there are a number of factors affecting VA's alignment efforts.

First, VA projects a 14-percent decrease in the veteran population by 2024 and continuing migration to the south and west. Second, similar to trends in the health care industry overall, VA's model of care continues to shift away from in-patient to outpatient settings. Third, VA is increasingly relying on care provided in the community. Fourth, an aging infrastructure means that many VA facilities are not well suited to providing care and it is often too costly to modernize, renovate, and retrofit older facilities. Fifth, the historic status of some 3,000 historic properties adds to the complexity of alignment.

VA has recognized the need to improve planning and budgeting to modernize its aging infrastructure and better align facilities with veterans' needs. VA's efforts have included the Strategic Capital Investment strategies, SCIP process, and the VA integrated planning process. However, both have limitations.

VA relies on the SCIP process to plan and prioritize capital projects, but limitations such as subjective narrative, long timeframes, and restrictive access to information limit VA's ability to achieve its goal. VAIP also has limitations. It is intended to produce market level service plans for each integrated service network and facility master plans for each medical facility at a total cost of more than $100 million. A limitation to this process is assuming that all future growth in services will be through VA facilities, which is unlikely given the increasing level of care in the community.

Additionally, VA has faced stakeholder challenges in its facility alignment actions from various groups.

Finally, VA has not consistently followed best practices to effectively engage stakeholders in these decisions or evaluated the effectiveness of its stakeholder communication strategies.

In the April 2017 report, GAO made recommendations related to capital planning and stakeholder involvement. VA concurred with

the recommendations to the extent they were within its control and has begun making improvements.

Regarding BRAC, as Congress evaluates the proposed Asset and Infrastructure Review Act, it may wish to consider seven elements DoD used in developing recommendations for the BRAC commission. First, establish goals for the process.

The Secretary of Defense developed three primary goals for BRAC 2005: Transform the military to be more efficient, promote enhanced jointness among the military services, and reduce excess infrastructure and produce savings.

Second, develop criteria for evaluating closures and realignments.

Third, estimate costs and savings to implement recommendations. Fourth, establish an organizational structure. Fifth, establish a common analytical framework. Sixth, develop oversight mechanisms for accountability. And, seventh, involve the art of community to better ensure data accuracy.

Finally, we identified two key challenges that affected DoD's elimination of BRAC 2005 and the results achieved. First, some transformational type recommendations require sustained senior leadership attention and a high level of coordination among many stakeholders. This was especially true of recommendations where a multitude of organizations had roles to play.

Second, interdependent recommendations complicated implementation. The BRAC Commission staff told us it was difficult to assess costs and savings since many recommendations remained multiple interdependent actions which needed to be reviewed. These challenges would need to be addressed if VA is to successfully apply a BRAC-like system.

Chairman Roe, Ranking Member Walz, and Members of the Committee, that concludes my statement. Brian and I will be happy to answer any questions you may have.

[THE PREPARED STATEMENT OF DAVE WISE APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Mr. Wise. Dr. Crump, you are recognized now for 5 minutes.

STATEMENT OF REGAN L. CRUMP

Mr. CRUMP. Chairman Roe, Ranking Member Walz, and distinguished Members of the Committee, thank you for the opportunity to appear before you today. Joining me today is my colleague, Jim Sullivan, the Executive Director of VA's Office of Asset and Enterprise Management.

Today we are prepared to discuss the Committee's draft Asset and Infrastructure Review legislation, as well as VA efforts already underway to modernize our health care system and infrastructure. VA will follow up later with views on H.R. 2773 regarding Pershing Hall.

The draft legislative text calls for VA to assess our health care markets nationwide, and determine ways to optimize the care and services we provide for veterans, and then submit recommendations to an appointed commission. The Department very much appreciates the Committee for its attention and commitment to the

effective use of capital assets and delivering high quality care to veterans.

The draft bill includes many thoughtful features that could serve as useful benchmarks for the market analysis, which is what we will use to gather focused, localized, and objective data for decision-making. As to the commission's structure and process, many of those requirements concern actions of Congress and so we defer to Congress. Regarding details of the draft, we would be pleased to follow up with the Committee to provide more in-depth comments and technical assistance.

Now, let me highlight what VA's doing with regard to building a high performing health care system.

One of Secretary Shulkin's top five priorities is modernize our systems which includes focusing on system streamlining and also infrastructure improvements. The Secretary is committed to modernizing our systems and infrastructure by focusing on primary care and VA's other foundational services, and the facilities where such services are delivered.

As the Secretary has emphasized, VA is moving forward with more efficient and agile management of VA's medical care facilities to match capabilities with where veterans live. The goal of our upcoming market assessments is to modernize VA's health care system using a data-driven approach for matching local capacity to local demand, and to create a modern, high-performing, integrated health care network in each market to better serve veterans.

These networks will be well-connected, comprehensive coalitions led by experienced VA managers who will coordinate VA health care services complemented, where appropriate, by other Federal and private sector providers. We must also continue leadership in our research health professions training and emergency preparedness missions.

These assessments are aimed at assessing current and future veteran demand for care and all the capabilities of local VA providers, DoD treatment facilities, academic affiliates, federally qualified health centers, other Federal, state, and local partners, as well as our telehealth resources. Achieving high-performing networks may require significant capital investments, clinical service line adjustments, process improvements, some targeted divestments, robust care coordination, and smart use of strategic partnerships.

The plans we pursue will undoubtedly require the continued support of Congress, VSOs, and other stakeholders to ensure success. In addition to VA's current authorities, we will continue to explore ways to leverage and establish additional capability and efficiencies with other Federal agencies such as DoD and GSA, as well as private sector partners.

Improved authorities to pursue joint facilities through construction and leasing actions will provide greater opportunities for VA to deliver 21st century care and services to veterans in state-of-the-art facilities nationwide.

VA recently submitted proposed legislation to the Committee, the draft VA CARE, C–A-R–E Act. That bill includes proposals to increase the Department's flexibility to meet veterans' needs such as increasing the major construction and lease thresholds; streamlining requirements for joint facility projects; creating VA–DoD pi-

lots for sharing health care resources without billing one another; and, expanding VA's enhanced use lease authority.

We must continually adapt to the changing needs of veterans we are privileged to serve.

Mr. Chairman, Ranking Member, and Members of the Committee, thank you for the opportunity to testify before the Committee today. We are glad to answer any questions regarding the draft bill and our approach to building high performing local health care systems for veterans.

[THE PREPARED STATEMENT OF REGAN CRUMP APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Dr. Crump. I will yield myself now 5 minutes. And I feel like I am back on the planning commission where I started my political career, except it is on steroids.

This is a huge undertaking that we are talking about today. And my recent trip to Northport, and to Canandaigua, and to Rochester a couple weeks ago really helped shape a little bit about I think you could make this trip in a lot of different areas and find out the same thing.

One is that we are now developing—and to look at Northport, it would take $450 million to invest into that plant and facility. And I think we have to look at not only how health care is provided today, but how it is going to be, as best we can figure it, Dr. Crump, 5, 10, 20, long after we are gone, that is what we are planning for now. Not for right now, but we are planning for 10 years, 20 years, 30 years what the VA is going to look like.

And I can tell you what it is looking like in the various facilities that I go to is that the inpatient hospital beds are shrinking, they have dropped dramatically. Sometimes 80, 90 percent in the VA, but the VA's done exactly the right thing. And I don't know what the VA would do today if it hadn't put CBOCs out there. I think that is one of the best things they ever did.

And this trip to Canandaigua and Rochester—and I also went to Rochester where they were shoveling dirt because of one of the leases that we approved on doubling the size of the CBOC where very modern health care, and the one they were in was just packed that day with patients. And they were at elbow to elbow, the providers were, and the veterans were. And I talked to many veterans there, and they love the care that they were getting at the CBOC.

So getting that in focus is going to be difficult. And I agree with much of what you all said. The timeline, absolutely, what the commission looked like, that is all debatable. We can get that figured out. What we got to figure out, and this will not be an easy undertaking, if we undertake this to do, but I think it is necessary to provide the best care for our veterans. And, right now, it is not—I can't imagine at my own VA at home, if all those patients who were at those CBOCs that were driving back on that campus, I can't imagine what it would look like.

So, Dr. Crump, I am going to start with you and go as quickly as I can, and then I have got a lot of questions that I will submit for the record.

Does VA support, in general, the draft bill, and will the Department be prepared to follow up with the Committee to provide more in-depth comments and technical assistance on it?

Mr. CRUMP. First and foremost, we would absolutely be available to provide additional technical assistance. And with regard to the bill, we are not yet clear whether or not there is a need for a commission, but there is definitely a need for the legislative flexibility to support us in doing a thorough analysis. And then we will, obviously, need ongoing support from Members of Congress and also from VSOs to implement those recommendations from that thorough assessment which is going to be based on the health care services we need.

The CHAIRMAN. Well, I can tell you one of my concerns very quickly is we had in 2004 when Secretary Principi tried to realign, Canandaigua was one of them. The only thing that happened, and Carl pointed out, clearly it was—actually it harmed the VA, it slowed down the—we absolutely don't want to do that. Without question, we don't want to do that again where you stop doing everything you should have been doing as far as capital projects are concerned. And if that indeed happened, that was a huge mistake on all of our parts. We don't want to make that mistake again, we learned that.

Two, once a contract is awarded to begin the local market capacity assessment, how long do you estimate it will take to complete assessments in all 96 markets? When will VA be able to tell us that?

Mr. CRUMP. There was a recent issue related to the contract. We did award a contract, there is a court order which is requiring a 60-day stay. So the earliest that we will know whether or not we will be able to proceed with the assistance of the contractor is December.

However, we will be able to start. And what we are estimating now is that we would do six VISNs at a time, I think we discussed that during the roundtable. There are about 32 markets in those six VISNs, and to do all of those simultaneously, mounting a VA team supplemented by contractors, we are now thinking it will probably be about 6 months for that group, 6 months for the second group of six VISNs, and then another 6 months, so probably 18 months.

The CHAIRMAN. Eighteen months. That was my next question, you just answered it, and I appreciate that.

Ms. Ilem, very quickly, and my time is about to expire, your testimony stated that it would be inappropriate and counter-productive in trying to reform the delivery of veterans health care, for the process to be closed, non-transparent, and inflexible.

But the Act clearly says that the Secretary to propose criteria, publish it on the Federal register, have a 30 day open public comment period, would require all information be used by VA to prepare for facility realignment recommendations be available to Congress, the commission, and the Government Accountability Office. Would require veterans and VSOs to be a part of the AIR commission, and would require that each meeting of the commission be open to the public, and that all proceedings, information and deliberation, be open to Congress.

Given that, what aspects of the AIR Act do you think are closed and not transparent?

Ms. ILEM. I think looking back at the CARES process, one of the issues that we saw in looking at this legislation that we feared is that there is not as much stakeholder involvement right from the beginning that we like to see. The biggest thing, I think, that, you know, started off on the wrong foot was not making veterans feel that they were involved in the process from the beginning.

They felt this was already done, and, yes, we are going to listen to you, or listen to what you say, we are going to maybe hold a hearing or have one, but not really being involved in that process, that decision-making process. Veterans feel this is their system, they are committed, they want to help provide what they think is best. And I think if as long as you may—there is a much better effort to do that right up front, and that they know what is being talked about and considered, and that they have that input from the beginning.

From New Orleans, the hospital when we were down there, and we got to tour it during our national convention, one of the things during the tour that really struck me, everywhere we went they said, veterans planned and laid out exactly how they wanted things in the facility, what was important to them from the infrastructure, the layout, everything. And you could really see that, you know, they had pride in—that that was considered, you know, that had been taken into consideration. So I would like to see that.

The CHAIRMAN. Mr. Walz, you are recognized.

Mr. WALZ. Well thank you, Mr. Chairman. I would concur with Ms. Ilem. I got the opportunity to see that New Orleans facility too, and just randomly stopped a veteran going through there and asked him what he thought of the place. He said, "I feel like I built it." And which was a really, really interesting comment. It is a fabulous facility, certainly needed, and I think that process goes a long way.

It is the front-end piece of this I was going to ask all of you and I think you started to answer it in great testimony. To think about what should this Committee be doing next? What, to build that trust? What, to have the partners truly engaged? Because I do think there is alignment.

We all know this is an opportunity, we have all been talking about it, but I do think creating those tools that can be used going forward rather than—I keep coming back to the snapshot-in-time picture and, you know, if I see that damn gas station at Fort Snelling again I will personally just go tear it down and we can move on with this conversation, because that really doesn't have anything to do with the delivery of this.

There is not an asset there to sell, it is probably not going to save money. But I got to be honest with you, I don't really know that for certain, I don't know what the tools are going to be delivered.

So, Dr. Crump, I am going to come to you. I don't know if you are at liberty to be able to tell me this. In those three, kind of, target markets out there in North Carolina, Georgia, and Washington State, you are developing and doing those assessments to develop

the methodology, are you learning anything? I mean, is there something there that starts to get us to where we are trying to go?

Mr. CRUMP. Yes, sir, we have learned a lot. I mean, the whole purpose of the pilot was, as you said, to develop a methodology, which I do believe we now have. We have been able to outline the steps of that methodology. Some of the things we did learn was the type of data and the volume of data that needed to be collected.

We also learned, as has been suggested before, that we need to involve stakeholders very early on in the process. We have also learned that we need to pull in a variety of assessments that had been done in the past, and any ongoing assessments. So we have learned a lot about that process.

We also learned that where we initially started out with this being more of a contractor-led, or a consultant-led, initiative. We also learned early on, or maybe later in the process, that it really must be owned and led by the network director and the market leaders for that health care market so that they own the recommendations and can advance those.

We have also learned that, in many instances, the need to partner with DoD, with our academic affiliates, there are some constraints to doing that and so that is why we talk about some legislative flexibilities. So those are some examples of lessons learned.

Mr. WALZ. Well, and I would like—I think this next part, I think this is our opportunity to think really big. I think right now as we are looking at it, we are still pretty narrow because the quote from DoD's process on BRAC was "reduce the amount of unneeded property that it owns or leases."

Well, when you look into this, that meant building up other places, being built up, shifting of assets. There is a whole bunch of moving pieces in this, and I think we have to be really, really careful, all of us in here, of not seeing this process on an ideological spectrum of shrinking government versus big government with small government, this is just-right size is what we are looking for.

I still am trying to get my mind wrapped around what is that just-right size. So, Mr. Wise, if I could just ask you. Your understanding, as our draft stands, is there anything in here that allows the VA to consider options such as building new infrastructure or leasing space for facilities that are more than 100 percent utilized?

Mr. WISE. Mr. Walz, GAO doesn't have a position on this draft legislation. It is not something we have had an opportunity to really study or comment on, but, of course, we are available to do so.

But to the point of your question, I think overall the question is it is a significant challenge for the Veterans Administration to be able to get at the points you were talking about in terms of rightsizing, and they realize that.

And the issue is that if you do implement a BRAC-like process, there are a number of things that need to be considered. And some of the testimony we have heard today alludes to those things. And one of the most important ones, as Dr. Crump noted, was bringing in stakeholders and being able to engage in effective communication because this was one of the key elements that was—has been a real problem with the SCIP process and, to a lesser extent, with the other efforts to realign VA facilities.

Mr. WALZ. Well, I have got some follow-up, my time is coming to end here, but I would encourage all. This is the healthy place we need to be. Carl brought up great points about we can't move our veterans population around by telling them to move to Joint Base Lewis-McChord because we are closing something else, it does not work that way.

But I do think there is an opportunity for us to think really, really big on this, and the tools necessary, and the assets, and getting this to—so that we are in a continuous process of reevaluation with the VA and not chasing our tail all the time when things get outdated.

I yield back.

The CHAIRMAN. I thank the gentleman for yielding. Mr. Coffman, you are recognize for 5 minutes.

Mr. COFFMAN. Mr. Chairman, I yield back.

The CHAIRMAN. The gentleman yields back. Mr. Takano, you are recognized.

Mr. TAKANO. Thank you, Mr. Chairman.

Mr. Wise, in your written testimony you highlighted significant cost savings DoD experienced following the five BRAC rounds. The majority's leadership is under the impression that by mandating VA undertake a similar process, it too could save hundreds of millions, if not billions of dollars.

Now, based on your understanding of the draft legislation and the challenges faced by DoD to carry out BRAC rounds, do you anticipate VA seeing substantial cost savings?

Mr. WISE. Congressman, as I mentioned earlier to Mr. Walz, we really haven't been able to analyze or study the draft legislation. But I think what I will do is I will bring Mr. Lepore in because he could tell you some of the issues that BRAC faced and how they got to their cost savings.

And I think it remains to be seen as to how VA goes about this process as to whether or not they will be able to realize significant cost savings going forward. But let me yield to Mr. Lepore who can give you some analysis of the BRAC savings and how they came about.

Mr. TAKANO. Well, but speaking as—based on the legislation before us, you really aren't able to say whether or not there would be cost savings. And you are not saying that there wouldn't be, but you are not saying that there will be either, as of this moment.

Mr. WISE. Yeah. At this point we are—I am unable to take any position regarding this legislation as we just haven't had an opportunity to analyze it and study it. But I think the points we made in our testimony, in our written statement, remain valid that, you know, VA faces significant challenges in trying to realign its resources. And those are the kind of things we pointed out that will be need to be done in order for VA to have any opportunity to realize cost savings going forward.

Mr. TAKANO. Well, before you yield, I would like to use my time, I want to give some of the VSOs a chance to answer a question I want to ask. I want to ask you a second question, though, and perhaps the colleague could answer on some other Member's time. But based on your knowledge of past BRACs, do you have any sense

of how much it might cost the VA to implement any closure or realignment recommendations?

All right, go ahead.

Mr. LEPORE. Congressman, my name is Brian Lepore, I am a Director of Defense Capabilities and Management in the Government Accountability Office, I lead the work that we do in the Base Realignment and Closure, or BRAC process.

It is difficult to directly answer that question, but let me say this. What we do know from DoD's experience with the defense base closure and realignment process, with respect to BRAC 2005, DoD is achieving cost savings.

We have done some analysis, we have reported twice now. DoD is achieving net annual recurring savings of about $3.8 billion.

Mr. TAKANO. Okay.

Mr. LEPORE. Because BRAC 2005 cost as much as it did, it turned out to cost $35.1 billion to implement, DoD has not reached the payback period yet. Next year they will finally take BRAC 2005 into the black. So right now we are still in the red in a process that started in 2005.

But if I might, to directly answer your question, we would need to know the nature of the recommendations that the VA put forward, and we would need to see the cost and savings analysis that was the part of that. So that is why it is a little hard to directly answer that.

Mr. TAKANO. I understand. So just all the more reason for us, I think, to proceed very, very, very carefully. Because we are not really sure, based on the methodology laid out here, that we could achieve cost savings. And it has taken many, many years, and you haven't yet, at DoD, hit that payback moment, right? I mean, you have had to spend money to close, but the savings has been realized very gradually over time, and we haven't reached that payback point yet.

Mr. LEPORE. Yes, that is correct. The other point I would make that is related to that is the decisions that DoD made after the commission had approved the recommendations were directly related to the cost.

In other words, a couple things happened. In several of the recommendations DoD omitted costs that were known to be incurred such as transferring people from one base to another. Indeed, DoD transferred over 120,000 people in BRAC 2005, none of those costs were estimated.

Similarly, decisions that were made later on how to outfit the buildings, places like the National GO Spatial Intelligence Agency's new campus in Springfield, Virginia, turned out to be about $726 million more than originally estimated just for some of the military construction type things. So it has to do with the decisions that get made in terms of implementing the recommendations the commission approved.

Mr. TAKANO. Well, thank you very much. My time is up, and I do have to move it along. Thank you, sir.

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

Mr. WENSTRUP. Thank you, Mr. Chairman. I thank you all for being here. I appreciate the input that we have received, I appre-

ciate the concerns that people have, and concerns on the process. We have concerns on the process as well; we want to get this right.

And I would recommend, as we move forward, if any of your groups have members that are practicing physicians or health care providers, please bring them into your conversations that you are having. I think that is important to bring them forward, people that understand the health care business, which is really what we are faced with today. And, especially ones that are practicing today, whether it is nurses or doctors. You know, bring them into the fold as you bring forward your ideas. I think that would be helpful to us.

You know, I consider this an asset review, you know. And we want to increase our productivity. And I have seen since I have been here, you know, VA will come in and say, well, we are producing more as far as patient care. I said, did you increase your hours? Yeah. Did you add more doctors? Yes. But did you actually take a look at how productive you can and can't be in a clinic, for example. To me, this is part of it.

If we have clinics that have one patient room, that is not going to be productive. If we have clinics that need a couple medical assistants to make it flow better, and we are not looking at that, then we are not increasing our productivity. That is all a part of what we are trying to do here.

Are we operating at maximum efficiency? And that is really what it comes down to. It includes your physical structure, your ancillary support, all those things come into play. And do you have the physical ability within that facility to create it? The CBOCs, for example, have been excellent. That is part of the modernization, that is part of this review, if you will, to actually look and see how effective they may have been in providing quality patient care for our veterans.

So it is a review of logistics and review of providing care, and a review of customer service. And I agree, the timeline we have may not be right. This is big and this is challenging, so it may not be right. But it is a matter of looking at what we have and what we don't have, what we need and what we don't need. That is really what this is all about.

And it is based, really, on current markets and future markets. We need to look at that. You are right, Mr. Blake, we can't move people, that is not the idea here, it is being able to fill the needs of the people. So that is part of the market review of what we are after.

And so, you know, when it comes to that, I don't consider this to be like a BRAC. We are not going to relocate people, right? So it doesn't fit into that same category, I feel, of what this Committee and what we should be trying to accomplish.

You mentioned Northport not having modernization. Well, maybe it wasn't modernized because no one did what we are talking about doing. Because no one looked at it and said, you don't have what you need. This is what we are trying to accomplish here.

So let's work together on really trying to make this about logistics, customer service, 21st century care, and do it in providing care in a quality fashion and a timely fashion. Because we are not out

here to snooker anybody, we are out here to make a positive difference for the future of our VA health care system.

So I don't really have a question, but I just would like to keep all those things in mind and understand what is in the heart and soul of this Committee, as I think it is, as we move forward. And with that, I yield back.

The CHAIRMAN. I thank the gentleman for yielding. Ms. Brownley, you are recognized for 5 minutes.

Ms. BROWNLEY. Thank you, Mr. Chairman. I wanted to first just make a very quick comment on Pershing Hall. And, from my perspective, I think that we really do have to dig deeper around this issue and we need to really research and dig for every possible option that is out there that can hold the Pershing Hall's historical value because I think what Mr. Takano said and what you said is very, very true.

And I think we need to get the value, I don't think that we should be in the hotel business, I agree with all of that, but holding onto a historical facility in some way is really, really important. And so exploring historical societies, other avenues where we might get the return that we are looking for but at the same time holding on, I think, to an important historic building that is very important to the history of our country. So I just wanted to make that one statement.

With regard to the other bill that we are discussing. I think that the reason why we keep referring to it as a BRAC, it is because the language in the bill that we are currently looking at right now, understanding that it is a draft language, mimics a BRAC process. So, therefore, I think we call it a BRAC process.

I agree with Dr. Westrup that, you know, it should be more of an asset review and driving for efficiencies. But I think just because of the nature of the language the way it is currently written is kind of sending the wrong message, I think, out there. That people really do feel like this will be a time-a-year process, and it is an up and down vote.

I do agree with the Ranking Member's opening comments that we really—I think the better approach is a much more of a continuous approach to this process, that we do have to adapt to changing needs, both in veteran migration and changes in health care delivery altogether. So that we need to be malleable every year in terms of responding to that.

I think veterans need to be at the table at every part of the process. We need their voice, that is critically important. And I just feel like if we start in a continuous process, it might be less complex in some ways. I sort of envision that there are probably, in this whole process, some easier decisions that are pretty kind of black and white about maybe we don't really need this facility, and it is pretty clear to everyone who is looking at this information. And incrementally it is going to get more and more difficult.

So if we are in a continuous mode, I think that we can right away sort of address some inefficiencies in identifying those that are more or less the easier ones. So I just wanted to make that statement. I think that we also are looking in this bill how to shut down, get rid of, however you want to quantify it, facilities.

We also have to look at improving the processes for expanding facilities and leasing facilities. And leasing facilities has been one of my bugaboos, that it is, it has taken 2 years to get a new group of leases done, and that we need to revert back to the old process where, you know, this Committee really does weigh in by resolution on these new leases.

So those two things have to kind of—we have to work on both of those issues, I think, simultaneously.

Right now I think the only question that I have is to the Chairman of the Committee, and if you could just help allay some of my concerns, I guess, by just trying to let us know how you perceive our process in terms of how we will proceed in terms of really discussing all of these issues and moving forward with changes, or amendments, or whatever. So, Mr. Chairman, if you wouldn't mind.

The CHAIRMAN. What I will do, since your time has expired, is I will go ahead and let the other Members, so if they have somewhere they have to go, and at the end I will address that.

Ms. BROWNLEY. Terrific. Thank you.

The CHAIRMAN. Mr. Bost, you are recognized.

Mr. BOST. Thank you, Mr. Chairman.

You know, earlier this week, and I want to thank the Chairman for doing this, both the Chairman and I held a tele-town hall meeting where we discussed issues specifically to the veterans in my districts. During that time we received a call from one of the veterans who spoke specifically about the assets that is held by the VHA, and many of my constituents in the northern part of the district used the VA hospital in Saint Louis.

However, for some in the Metro area, it is still difficult to get to Saint Louis. So I guess the question I have is for you, Dr. Crump or Mr. Sullivan, whichever, is do you believe—and I think that we have answered it before but I would like to expand on it—that the proposed legislation could lead to increased assets of VHA like CBOCs in areas like high veterans populations such as at Metro East?

Mr. CRUMP. Well, I can't speak to whether or not the legislation itself will lead to that, but I can speak to the shifting demographics of veterans in the modernization of health care. I mean, it is very clear to us, as has been shared, that our inpatient care demand is going down like 4 to 10 percent a year, whereas our outpatient demand for care is going up like 10 to 20 percent per year. So that is why we have had to add more community-based outpatient clinics, and we will continue to provide more ambulatory care.

The other thing is, telehealth has given us the ability to utilize excess capacity in one part of the country to provide care in another part of the country. And so it is our definite intent to work through VA improving efficiency, partnering with DoD, and realigning assets to where the veterans are to deliver more care using more outpatient services, fewer inpatient services, but also addressing the increased demand for some mental health services, and use of ambulatory care and telehealth services.

Mr. BOST. Yeah. That is what we really want. My other question here is, basically, to the VSOs. At any time have you been discussing with the VA, if we go forward with this, what the communications will be with the veterans in the area where maybe there

is a relocation, maybe there are all of these things that occur that they would then have an open communication with the veteran to communicate on how their services and the way they receive their services might be changed? Have you had those conversations?

Ms. ILEM. I would just say, we have, I think, brought it up in terms of this stakeholder engagement and how they would communicate and having really effective engagement early on in the local communities, that that is important. But also with the service organizations so we can help educate, that we can help explain, and that we can also get them, you know, where they need to be to have their input considered, and look at the big picture. So I think we have mentioned it in our discussions as these draft bills have been considered.

Mr. CELLI. So I can tell you from The American Legion's perspective, we also included that in our written testimony. You know, there was a portion of the bill that talks about conducting public hearings at every location where there could possibly be a reduction in buildings. And, you know, we questioned the logic of having a public hearing if it is only a storage facility, or if it is a gas station, or if it is something that is no longer used. But we absolutely demand and require, you know, public hearings where health care is going to be affected. And I think that is going to be a critical component to this.

Mr. BLAKE. Mr. Bost, I think it is no secret that veterans in many local communities don't have any idea what the heck is going on at their local VA facility, even when they are regular users. I mean, I think one of our chief complaints that we hear about is there is no effective communication about major changes that are going on.

And so now we are going to go down this road with a process where we are going to hope that VA is going to conduct public discussion and public interaction with those people in those local communities. It doesn't really happen effectively now, so it is serious concern we have if we are going to go down this road.

Mr. FUENTES. We will make sure that happens, and we will certainly participate in the process to make sure that, you know, for the VFW, our members are there or represented. But the key is that the plan is what veterans want, right? Because often you can listen to them, you can have a hearing, but then VA goes a completely different route and that is where you get the issue. Right?

We are a membership-based organization, and if my members, VFW members in any particular area aren't happy they are going to come to us and they are going to say, do what you can to stop it, and that is exactly what I am charged to do.

Mr. BOST. Okay. My time has expired. I yield back.

The CHAIRMAN. General Bergman, you are recognized for 5 minutes.

Mr. BERGMAN. Thank you, Mr. Chairman. Am I last? I am not going to say you saved the best for last, you saved the oldest for last. That is how it works.

You know folks, I have got one simple question, and I am going to ask each of you to answer it in a couple sentences. And we are going to start right here with Mr. Sullivan. You haven't had a

chance to talk much today, so this, but simply, in a couple sentences, I want you to tell us why we are here today.

Mr. SULLIVAN. We are here today to look at how we can realign our services to provide more efficient and more effective health care services to our veterans. And look at what are the tools and what are the authorities that we need to deliver those to where the veterans are, where they want to have it delivered, and what is the best way to deliver it to them.

Mr. BERGMAN. Okay. Mr. Crump.

Mr. CRUMP. I believe and hope that the reason we are here today is to figure out how VA, VSOs, and Members of Congress, and other stakeholders can work together effectively to make sure that we utilize our assets and resources most effectively to increase access, improve quality, and also make sure that we improve satisfaction of the care that veterans receive. They have earned it, and we need to make sure that together we will work to make sure that we deliver it.

Ms. ILEM. I would concur that we hope that we are here to collaborate. To listen to each other, to have a voice, have a say, be part of the discussion about the future of VA health care. I think everybody has the same goal in mind: wanting to improve services, ensure veterans are cared for with timely, quality health care throughout the country. And this is the start of the conversation to help foster that.

Mr. CELLI. I would agree, and I would agree with Mr. Sullivan's comments. This is the beginning of the conversation; it is not the first one, but it is the beginning of the conversation of how to modernize VA with 21st century health care for our veterans, and without talking about capital assets and infrastructure we can't have that conversation. But we also have to make sure that we know where the services are needed. So I think that this is a step in the right direction.

Mr. BLAKE. We are here to ensure veterans get timely quality health care in the best setting and that includes making sure VA is properly positioned to deliver that care, or is able to work with the community to do so.

Mr. WISE. Everybody has been so eloquent, it is hard to come up with something original. But I think one thing, and a couple of the Members have, I think, alluded to this, is that it is important that while there can be a lot of really positive lessons drawn, or lessons as a whole drawn from BRAC, I think it is important not to overstate the BRAC- VA connection because their missions are so different, and the population is very different. Their needs, and their physical locations, and everything that goes about them is so different that it is important that it can be used as a learning tool, but understand the differences as well as the similarities.

Mr. LEPORE. It seems to me we are here to assist you in developing legislation that gets the best possible care to our veterans in the most efficient way possible and at the best possible cost.

Mr. FUENTES. I completely agree. I mean, we are here to get this right, to make sure that there are no gaps in access to care, and that veterans and the care that they receive are improved by the outcomes of whatever this Committee passes and becomes law.

Mr. BERGMAN. Okay. Well, thank you, each of you, for putting in your own words because you heard all the Committee Members who spoke. We all have our own view and our own words. And communication is not what is said, it is what is heard. And, you know, in the military we are big on mission statements because if you can't write a mission statement concisely, then your commanders in the field are not going to be able to execute that mission to the success that they need to for the positive outcome.

So, number one, I know you are all in the game, and those of us who played in the congressional football game last night had a chance to play many different positions, and figure out that we were sometimes running in different directions, but we are all headed towards the same end zone.

And I would suggest to you that in the case of, you know, the why that we are here today, I just wrote up a quick mission statement, this is my version, and that we are all in this together because you are here because you are part of this large team that has a dog in the fight here. We are all in this together to serve our veterans in a forward-thinking way, which means we have to shed some of maybe the concepts that we have used that maybe are not going to work in the future.

So in a forward-thinking way that maximizes veteran outcomes, and minimizes waste, utilizing limited resources. So maximize outcomes, minimize waste, limited resources. So as we work together, this is our opportunity to make the change necessary for the future.

I see I am over my time, and I yield back, sir.

The CHAIRMAN. I thank the gentleman for yielding. And the mission statement last night of the congressional football team was to get into the end zone, which they did not accomplish.

Mr. BERGMAN. No.

The CHAIRMAN. So I would point that out.

I thank the panel for being here. Once again, I think it is we are in the beginning of a process, and I appreciate your comments, and really appreciate all of you being here and the time you have put into it so far. But we are going to continue to explore this because it is that important.

I understand that we have a special guest here today that I didn't know at the time, and I will yield to my good friend, Tim Walz, to introduce this guest.

Mr. WALZ. Well, thank you, Mr. Chairman. As before my closing here, as a point of personal privilege, my wife Quinn, a military spouse and so much more, has my 10-year-old son, Gus, here. He wanted to believe I really had a job, so he is here to see it. So, thank you.

The CHAIRMAN. And have Gus—there he is.

Mr. WALZ. That is Gus. Well, thank you, Chairman. And we all know organizations have written mission statements and unwritten mission statements. And as the co-captain of that football team, the true mission statement was to be walking today after that football game. So, General Bergman, congratulations on accomplishing that.

Thank you all for being here. You are partners, friends, you represent us who are in your organizations. More importantly, you

represent those voices of millions of veterans and their families who are out there today and can't be here. And I would say, once again, it is not just lip service, that this Committee is proving that there is no place on Capitol Hill or no place, certainly in Federal Government right now, where the true spirit of working together, building collaboration, and trying to move things forward for our veterans is actually happening.

It is one thing to say that, everybody wants to say that, every Committee says we are super bipartisan. Well, move things, get things done together, and being bipartisan doesn't mean agreeing on everything. But it does, as the General, and the Chairman, and so many others have said, it does having the common goal. So we know what needs to—we know how this process works. First and foremost, all the stakeholders must be included and they must be included early, and they must be legitimately included with their ideas.

We must then figure out, using evidence-based decision-making, put together plans. Legislation is over at legislative counsel right now with folks trying to squirrel this. And then we need to be pragmatic. Not every four-letter word has four letters, and the United States Senate is one of those places. And we all know that we have to deal with those places.

We have to make sure that the Senate is on the same sheet of music. We need to make sure, before we do anything, we are moving everyone together in the VA. And as we were just mentioning up here, that is happening. That is starting to happen that people are talking and moving that.

So nothing is going to be done that violates those basic principles. General Bergman laid them out, I think we are all pretty much in agreement with that. Highest quality care, good stewards of the taxpayer dollars, and thinking about what is possible.

But this is the opportunity. I have been saying it, and, General Bergman, you said you were last, I have been there, so I know. That was 10 years ago that I was sitting down, it was on this side, down in the end, saying we needed to have this idea, we needed to think about this.

I remember all of us saying, those wars have been going on for 5 years and could go on a couple years longer. That is what we were saying back in 2007, and that is going to create all kinds of things moving that we are going to have to think about.

So I am grateful you all are here. Mr. Chairman, I once again thank you. There is probably not any more difficult thing in the realm of dealing with veterans and veterans issues than this topic, and you have done it.

And to the folks sitting here, your good faith effort to approach this is so sincerely appreciated because we have to get this right.

I stick with the statement that I made: time is not on our side. This is one of those things that must be dealt with, it cannot be kicked down the road. But amongst that, it must be done right because we are not going to get another bite at this thing. This is one of those where I truly believe the time is probably right to try and do something, and it may take a little longer than we anticipated, that is fine, but having the discussion happens now.

So thanks to all the Members, thanks for the work.

And, Mr. Chairman, again, I thank you for your willingness to not dodge difficult things, for your willingness to put us in things that maybe challenge us and makes us uncomfortable, but gets at the heart of what we should do. And I yield back.

The CHAIRMAN. I thank the gentleman for yielding and his kind words. I will answer your question, sort of, Ms. Brownley, in my closing comments.

Medicine is changing almost at light speed, and I don't think we have even begun to see the changes that are going to happen. Dr. Crump mentioned telehealth, precision medicine. We are going to see things. And, remember, I was on two VA facilities that penicillin had barely been invented and discovered when those facilities were opened.

The facility I had at my hometown was there before there were any antibiotics, penicillin, and a hypertensive anything, 1903. And that facility is still functioning today as an outstanding VA medical center, four-star, I think, soon to be a five-star medical center.

As I visited Northport and Canandaigua, I looked at those facilities and we were mentioning, I think Mr. Takano mentioned about savings, that is not what this is about. It is about getting the VA right-sized so it can carry out its mission, which is to take care of veterans who have served and were injured, or had conditions that occurred because of their service to this great country.

And I looked at, when I went in there, there are two buildings that are historic that the roofs had collapsed, and it is going to cost $10 million just to destroy those buildings because they are on the historic registry, even if you can do it. That is just at one center.

And I asked those folks, I said, look, what do you guys do really well here? And they have a great PTSD treatment. I said, that is something that you do and you do well at this campus, and should—you can inpatient put people—we know that mental health is a huge need in this country, and 35, 40 years ago we had 500,000 mental health beds in this country, now we have less than 50,000. And we see the problem we have now in this country of mental health, the needs are not being met. We see those in our veteran population.

So the thing that those injuries that occurred because of your service, the VA should focus like a laser beam on. And I looked at the five CBOCs they had along Long Island, which is a beautiful area, beautiful part of this country if you haven't visited. I said, those things should be updated and really enhanced, and we should really be putting those resources so our veteran doesn't have to drive long distances.

I go to Rochester, and I see Canandaigua, and I think where are the veterans going? Well, they are going where the VA is accessible to the most VAs. And that is where you brought up and you have leasing, which is going to be a huge part of this. And the average lease, and I have done it many times in my private practice, is about a 3-year thing too. You conceptualize what you want to build and you get your contract, you build it, and you move in. VA, it is 9 years, and people may have moved by then.

So they have to be more nimble. We have got to give them the tools to do that, that is part of it. We know that we are going to vote on our Choice legislation in about 3 weeks. And we know that

not only is Choice important to get that done, but we are going to implement an EHR change which is going to change how VA carries out its care at the same time. And that is going to be a 6 or 7, or 8-year process. This is a multi-year process.

It could be that gathering—and we are going to need to know what those networks look like before you can implement the Choice Program in October of 2018. And those panels will look different as our health care—just like in my own health insurance plan, my panel may look different this year than it did last year. So that will be a continuum of changes that occur.

And we mentioned, I think, HR was mentioned about staffing and hiring. The VA has hired more nurses and doctors and other providers, but it certainly has shortages, and that is where Choice will help provide those care, where those shortages are where VA doesn't have those assets in place.

If it were me and I were a VISN director, I would clearly have a vision about where I want—what I want to do with my VISN. And there are many of those, as you all know, across the country. And what are my strengths, what are my weaknesses, and how can I help amplify my strengths and fill in my weaknesses.

And in thinking about what is care going to look like and one of the reasons that we brought the asset review in is to do just that. But we have problems that, politically, and we will all admit that we are weak when it comes to our districts. I mean, we have a facility in Hot Springs, South Dakota, it is really very black and white what should be done and, yet, it isn't being done. So that is one of the reasons that we did that.

I think what we need to do—and, first of all, I can't thank you enough, I have got a lot of information here and a lot of ideas, I just need time to, as we all do, but I think that is what we need to do.

And to Mr. Correa when he mentioned, look, I am a guy that believes when I was a mayor of a city and a planning commissioner, I don't think you turn over those assets, that being property, casually.

You bring the local community in, can this be used, and I will give a perfect example. On our campus at home, at our VA, we have a pharmacy school. It is basically a public/private partnership, that we built a pharmacy school with private donations, it is a state school and it is housed in a rehabbed building on the VA campus in Johnson City, Tennessee.

So those are the visions that we, as leaders, and as leaders at the VISN level and at the local community level, have to have, I think, to make this actually work. So I look forward to sitting down and continuing to work with all of you all about how we can get this process done, because I agree with Mr. Walz, it is absolutely mandatory that we do it to provide the care we need for our veterans.

And, again, I want to thank you all. And 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.

Hearing is adjourned. Thank you.

[Whereupon, at 12:24 p.m., the Committee was adjourned.]

A P P E N D I X

Prepared Statement of The Honorable Mike Coffman

Mr. Chairman, I would like to begin by thanking you for including my bill in today's legislative hearing and thank the witnesses for their testimony.

Mr. Chairman, I think we can all agree that the VA's sole mission is to provide services to our nation's veterans.

The maintenance of a 5-star, 24-room boutique hotel, restaurant, and club in downtown Paris, France is clearly not included in that mission.

Therefore, in an effort to get the VA out of the overseas hotel business and focused on its core competencies, I introduced H.R. 2773, the Sell Excess Luxury Lodgings (SELL) Act, to authorize the sale of this hotel - "Pershing Hall."

Pershing Hall is a building originally procured by the American Legion to serve as a memorial to our "Doughboys," who served in France during World War I. The building was transferred to the VA in 1991, and in 1998, the VA leased Pershing Hall for a 99-year period to a French firm that redeveloped the property as a luxury hotel.

In recognition of the historic aspects of Pershing Hall, H.R. 2773 requires the preservation of architectural details of the exterior and interior of the structure, and requires all property of General Pershing and the American Expeditionary Forces in France during World War I to be transferred to the American Battle Monuments Commission.

H.R. 2773 also appropriately requires the transfer of sale proceeds to the American Battle Monuments Commission for the maintenance of cemeteries, monuments, and memorials dedicated to our men and women in uniform.

Mr. Chairman, today you will hear the concern that the fair market value will not represent the true value of the property because it is encumbered by the VA's lease. Unfortunately, the reality is that the VA negotiated a bad, long-term deal that significantly decreased the market value of the property. Even more of a reason to get the VA out of the hotel business.

To address this concern, I plan to amend my legislation to require a condition of sale be the appraised value of the property.

While Pershing Hall is probably a terrific hotel, it makes no sense that the VA keeps a luxury hotel in Paris on its books. The VA needs to focus its time and resources on its core mission: taking care of our nation's veterans.

Mr. Chairman, thank you for allowing me to testify today on behalf of this legislation and I yield back the remainder of my time.

Prepared Statement of Joy J. Ilem

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.

Prepared Statement of Louis J. Celli Jr.

Chairman Roe, Ranking Member Walz, and distinguished members of the Committee on Veterans' Affairs; on behalf of National Commander Denise H. Rohan and The American Legion, the country's largest patriotic wartime service organization for veterans, comprised of more than 2 million members, and serving every man and woman who has worn the uniform for this country, we thank you for inviting The American Legion to testify today and share our position regarding The Department of Veterans Affairs' (VA) Asset Infrastructure Review.

Draft legislation, the Asset and Infrastructure Review - or AIR - Act of 2017

VA currently maintains a complex physical infrastructure of thousands of buildings that deliver coordinated care to more than nine million enrolled veterans. Over the years, many of the buildings VA uses to deliver this care have been left to deteriorate in favor of fiscal savings, leaving veterans with a collection of aged infrastructures. The VA, Veteran Service Organizations (VSOs), Congress, and even the Commission on Care have long known that VA needs to clean up their physical inventory of properties by: discarding some, rehabilitating others, and rebuilding where demand requires it; and this rehabilitative process is what needs to happen today.

Since we are addressing infrastructure, capacity, and fiscal responsibility through this legislative discussion draft, The American Legion requests that this Committee use this legislation as a vehicle to expand VA's leasing authority to avoid future funding and jurisdictional hurdles that VA and Congress have struggled with over the past four years.

The American Legion appreciates the Committee recognizing their need to support the Secretary as he works toward streamlining and organizing the physical property VA is responsible for maintaining. We also applaud the Committee for ensuring that VSOs are integral in this process through round table discussions, staff meetings, and this hearing.

Comparisons have been made between the proposed Asset and Infrastructure Review process contemplated by this draft legislation and the Base Closure and Realignment Commission (BRAC) process the Department of Defense (DoD) has used to realign and close excess bases. It is important to note that BRAC was established because DoD had reduced its active duty force from nearly 3.8 million active duty personnel following Vietnam, to just over 1.3 million in 2000. This is clearly not the case with VA, and the need to restructure is based on the need to refurbish and modernize infrastructure so that VA can provide 21st century medicine to a growing population of veteran patients at a controlled cost with superior results.

The American Legion fundamentally disagrees with the establishment of a commission to oversee or assist the Secretary with structural realignment and generally opposes such a recommendation believing that the Secretary already has sufficient statutory authority to reorganize infrastructure, and would only need some minor legislative assistance from Congress, legislative changes that VA has already shared with this Committee in the past, and has shared here again today. But if establishing a Commission is the only way Congress will agree to financially invest in this effort, then The American Legion would require the following language be amended as follows;

1. Page 2, line 8 (A) APPOINTMENT - Change from 11 members to 9 members with three of those members appointed from Congressionally chartered Veteran Service Organizations (VSO). Further, language needs to be added that directs "a quorum must consist of all nine members, and all official votes must be ratified by no less than two-thirds of the voting members." The next acceptable number of

Commission members would be 12, with no less than 4 members appointed from Congressionally chartered VSOs. Additionally, a VSO seat on this commission must belong to the VSO, not the individual representing the VSO, and the VSO has sole authority to replace its representative at any time; any vacation of the seat shall be refilled by the VSO within 10 business days.

2. Page 3, line 16 (A) veterans, reflecting current veteran demographics: This needs to be further defined. Reflecting current demographics of VA healthcare patient population is what The American Legion would recommend, as this would be the population most affected by future changes based on this initiative.

3. Page 4, line 12 (E): "at least three members" needs to be increased to "at least four members" unless item 1 above is changed to nine members.

4. Page 4, line 15 (d) Meetings - The Commission shall meet only during calendar years 2018 and 2019. This should be amended to reflect 2018, 2019, and 2020 as needed. It is widely believed that VA will need at least 18 months to complete the required healthcare market surveys before they will be ready to publish the selection criteria as outlined in section 403.

5. Page 6, line 16 (f) PAY AND TRAVEL EXPENSES - The American Legion understands that the members to be selected for this Commission would represent multimillion dollar organizations as well as other senior executives who should be well capable of serving at the pleasure of Congress for the sole purpose of volunteering, pride, patriotism, and the prestige of serving on this important Commission. It is for this reason The American Legion opposes Committee members being paid or being enriched in any way as a result of serving on this Commission, and that includes the Chair as outlined on page 7, line 3 (B). This is not, however, our position on the fulltime support staff as described on page 8 line 7 (2) RATE OF PAY.

6. Page 9, line 13 (C): Strike this section unless there is some prohibition as outlined in the Federal Advisory Committee Act.[1] If this Commission were fortunate enough to have an appointee that had been instrumentally involved in this process as an employee at VA within 12 months of appointment, The American Legion is at a loss to understand the logic of how this could possibly present a conflict. On the other hand, contractors who would be in a positon to benefit financially from the outcome of the Commission's work should be excluded.

7. Page 14, line 1 (H): Remove this clause. The Secretary has no experience or access to information that would qualify him to make any such determination on any other than his own agency.

8. Page 14, line 8 (J): insert "a reasonable sampling of" before "Local". It would not be feasible for the Commission or the VA to conduct public field hearings at every proposed location targeted for infrastructure review, especially if the proposed realignment only involved a storage or maintenance building. The language should include mandatory field hearings for any facility that provides direct medical services for the Department.

9. It needs to be understood that the market analysis as directed by the clause in page 14, line 22 (i),(ii),(iii),(iv),(v) will take more time than this bill allows for, which is why The American Legion recommends extending the dates set forth in this proposed draft to dates agreed upon by the Department.

10. Page 19, line 20 (C) needs to be changed to: The Commission "will recommend changes to the Committees of Veterans Affairs of the House and Senate". The American Legion adamantly opposes granting the Commission unilateral authority to change or amend the recommendations of the Secretary.

11. A clause needs to be added that prohibits land sold or granted to the VA from being included in any recommendations by this Committee that would result in violation of a trust, agreement, or deed such as would be the case with the property located in West Los Angeles, California.

Without these small but extremely significant changes, The American Legion WILL NOT support this bill and will aggressively oppose any efforts to allow this bill to move forward.

Provided these issues can be sufficiently addressed, The American Legion would be able to support this effort and further supports the overall theme of what this

[1] https://www.gsa.gov/policy-regulations/policy/federal-advisory-committee-management/legislation-and-regulations/the-federal-advisory-committee-act

Committee is trying to do - reorganize, build capacity, and eliminate waste within The Veterans Health Administration at the Department of Veterans Affairs.

We particularly appreciate that this effort would be led by the Secretary of Veterans Affairs, beginning with the establishment of selection criteria, through the selection of locations, and including the maintenance of funds responsible for carrying out this much-needed reform.

We also fully support the provision starting on page 12, line 21 (A) & (D) that calls on the Department to establish a market analysis for providing healthcare for eligible veterans, and again remind this Committee that this market analysis will take time to complete, analyze, and implement, and the only realignment that can possibly be committed to before this analysis is complete would only involve the 1,100 structures the Secretary has already identified for disposal. All further restructuring will need to be recommended after the healthcare market analysis has been completed.

With an appreciation and understanding of these requirements, The American Legion asks this committee to consider structuring this project into more than one round of recommendations, allowing VA and the Commission to fully develop the research necessary to implement this program properly, while allowing sufficient time for proper analysis and execution.

The American Legion could support the AIR Act of 2017 with the changes recommended above.

H.R. 2773

To authorize the Secretary of Veterans Affairs to sell Pershing Hall

Nearly 100 years ago, members of the American Expeditionary Force in World War I came together to "preserve the memories and incidents of our associations [in] the Great War[s]"[2] and as the 100th anniversary of our founding approaches, The American Legion is still dedicated to that mission. As such, a primary charge of The American Legion is to ensure the sacrifices of America's military is not forgotten.

The American Legion fought for the dedication of a memorial building in Paris, France, the city where The American Legion was formed, to recognize the service and sacrifices of the members of the American Expeditionary Forces and General of the Armies John J. Pershing. The memorial building was a townhouse in the heart of Paris that would become known as Pershing Hall. This memorial was sanctioned by resolution at our 1927 National Convention. Eight years later, in 1935, Congress authorized funds to perpetuate the memorial and transfer the building to the United States Government under the auspice of The American Legion. In 1991, the building was transferred to the Department of Veterans Affairs (VA) with the intent that it would be used to "administer, operate, develop, and improve Pershing Hall and its site in such manner as to the Secretary determines is in the best interests of the United States, which may include use of Pershing Hall to meet the need of veterans. To meet such needs, the Secretary may establish and operate a regional or other office to disseminate information, respond to inquiries, and otherwise assist veteran and their families in obtaining veterans' benefits".[3] Unfortunately, the building was not used in this manner, but instead, the VA leased the building to a boutique hotel on a 99-year long lease.

Through all these actions, it was the hope and wish of The American Legion that Pershing Hall retain its original purpose, as a memorial and focal point to honor the memories and sacrifices of the men who had fought in World War I, and as a location for veterans in the region to gain assistance from the VA. Although The American Legion does not fully agree with this legislation, we do agree with the bill's sponsor, Representative Coffman, that the VA is not capable of appropriately maintaining this location while meeting the congressional intent of the 1991 legislation.

Currently, the Pershing Hall building, in the prime Paris neighborhood of the Champs Elysees, contains a luxury hotel and spa, where guests can stay for upwards of $450 to $900 a night. The focus and purpose as a place of remembrance seems gone by the wayside. The building is available to veterans' organizations three days a year, but access seems to be difficult to obtain. When The American Legion asked the government to assume control of the building, it was never imagined that Pershing Hall would be used for any purpose other than as a memorial

[2] https://www.legion.org/preamble
[3] https://www.congress.gov/bill/102nd-congress/house-bill/1047/text

and VA service office in Paris for those who had served in the First World War and subsequent wars.

This legislation would authorize VA to divest itself of the property and transfer the monies resulting from the sale to the American Battle Monuments Commission (ABMC). The legislation would also provide for the transfer of the artifacts and items associated with the building to ABMC.

The preservation of these artifacts and the history they represent is a major concern of The American Legion. The materials deserve to be kept together for the original purpose, to honor and remember General Pershing and those who fought in World War I. The American Legion wants to work with VA or ABMC to "establish permanent American Legion custodianship of the Pershing Hall art, artifacts, furnishings, memorabilia and other items so that they can be interpreted for public display, and protected from damage or disappearance." [4]

The American Legion has serious concerns with selling Pershing Hall. Currently, the building is in a 99-year long lease with a company that renovated it to become a hotel. The assessed value, according to a report developed by a French appraisal company, values the building without the lease at 70 million Euros or 82 million U.S. dollars. However, with the current lease in place, the value of the building is appraised at 7 to 8 million Euros. The new owner of the building would be required to honor the 99-year long lease, which lowers the value drastically.

American Legion representatives in Paris have learned that the intent of the hotel owner is to buy the building using "first rights of refusal" at the assessed value of 7 to 8 Euros when the building becomes available for purchase. The owner then wishes to terminate the lease once they have ownership of the building. By doing so, they would automatically own a building worth 82 million dollars. The American Legion has also heard that the intent is to then sell the building, with the new value of 82 million dollars, and open a chain of Pershing Hall hotels around France.

Again, when The American Legion transferred ownership of Pershing Hall to the Federal government, we never expected this building to be used in such fashion. We are disheartened that Pershing Hall is not a military memorial or space for veterans to receive information about VA benefits but instead a boutique hotel with an owner intent on making millions of dollars off the Federal government. We are even more concerned with the blatant disregard to the second or third order effects of selling this building to a private organization.

The American Legion believes that Pershing Hall should remain in the ownership of the Federal government. We are displeased as to how VA decided to use the building but also understand that America, its people, and the need for memorials and VA assistance will be around in 99 years once the lease is terminated.

If Congress is willing to wait until the lease has ended so that veterans will have a location to gain assistance, The American Legion is willing to wait as well. To ensure this historical American building is protected, we recommend either transferring this building to ABMC or amending the statute deriving from Public Law No: 102–86 from:

"administer, operate, develop, and improve Pershing Hall and its site in such manner as to the Secretary determines is in the best interests of the United States, which may include use of Pershing Hall to meet the need of veterans. To meet such needs, the Secretary may establish and operate a regional or other office to disseminate information, respond to inquiries, and otherwise assist veteran and their families in obtaining veterans' benefits", [5]

to:

"administer, operate, develop, and improve Pershing Hall and its site in such manner as to the Secretary determines is in the best interests of the United States, which shall include use of Pershing Hall to meet the need of veterans. To meet such needs, the Secretary shall establish and operate a regional or other office to disseminate information, respond to inquiries, and otherwise assist veteran and their families in obtaining veterans' benefits".

We would also recommend adding a clause that protects the building from sale to a private organization in the future.

The American Legion is grateful to Representative Coffman for his ongoing work with The American Legion and his continued work on behalf of veterans, and respects the fact that he is doing what he feels is right, as a follow up to ensuring the VA medical Center in Aurora Colorado was sufficiently funded, but we cannot

[4] https://archive.legion.org/handle/123456789/5798
[5] https://www.congress.gov/bill/102nd-congress/house-bill/1047/text

support legislation that would sell an American monument to a private company, thereby losing an American historical monument.

We feel that this legislation is a short sighted attempt and a quick fix to a larger issue within VA, and ultimately by selling the building, veterans lose. It is disconcerting and troubling that this site could have drifted so far from its initial intended purpose as a place of remembrance and history. We look forward to working with Congress to find the best outcome for this historic building.

Using resolution No. 9, Transfer Custodianshipo of Pershing Hall Building and Artifacts to the American Battle Monuments Commission, which supports legislation to transfer custodianship of the Pershing Hall Building and artifacts from the Department of Veterans Affairs to the American Battle Monuments Commission (ABMC), and ABMC be directed to restore, preserve and display all artifacts from Pershing Hall, including those currently in storage, in a dignified and respectful manner either in Pershing Hall itself, or in ABMC or other federal government properties. Because H.R. 2773 goes against this resolution, we cannot support. [6]

The American Legion opposes H.R. 2773.

Conclusion

The American Legion looks forward to continuing to work closely with VA and this Committee on these important issues and we applaud the Committee for working with VSOs and VA as partners to ensure that The Department of Veterans Affairs is properly structured to meet the needs of the 21st century veteran.

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. Derek Fronabarger at The American Legion's Legislative Division at (202) 861–2700 or dfronabarger@legion.org.

Prepared Statement of Carl Blake

Chairman Roe, Ranking Member Walz, and members of the Committee, on behalf of Paralyzed Veterans of America (PVA) I would like to thank you for the opportunity to testify on this critical subject. There is no doubt that the Department of Veterans Affairs (VA) capital infrastructure footprint needs assessment and realignment to properly meet the demand for health care across the system. As emphasized in The Independent Budget Policy Agenda for the 115th Congress released in January of this year, we believe that VA must make a concerted effort to right-size its infrastructure, in light of the amount of unused and underutilized capacity in the system. To that end, we appreciate the Committee conducting the recent round table to bring all stakeholders into the discussion about how to proceed with necessary infrastructure realignment.

It is important to note that the Commission on Care addressed the need for an asset review process in its final report released in 2016. In fact the Commission report explicitly stated:

Congress should enact legislation, based on DOD's BRAC model, to establish a VHA capital asset realignment process to more effectively align VHA facilities and improve veteran's access to care. Creating a robust capital asset realignment process is vital because previous capital divestiture efforts have failed. This process should offer a level of rigor far beyond what currently exists for repurposing and selling capital assets. It should require VHA to.conduct locally-based analyses of capital assets. Information generated would be used to assist an independent commission, established under the legislation, in making recommendations regarding realignment and capital asset needs. The independent commission would conduct a thorough, one-time process, to include making site visits and holding hearings to inform recommendations that would constitute a proposed national realignment plan.The commission would be empowered to implement the recommendations unless, within a specified timeframe, Congress disapproves the plan on an up or down vote.

The draft bill presented today suggests that the Committee is interested in pursuing this recommendation as outlined in the Commission report. However, we cannot emphasize enough that we are not convinced that a Base Realignment and Clo-

[6] The American Legion Resolution No. 9 (2016): Transfer Custodianshipo of Pershing Hall Building and Artifacts to the American Battle Monuments Commission

sure (BRAC) modeled concept, as previously used by the Department of Defense (DOD) is the most effective way for VA to realign its capital footprint. This is the position we took on the Commission's recommendation last summer and our position has not significantly changed since then. That being said, PVA generally supports the intent of this proposal, assuming the intent is to right-size the VA and not simply use this opportunity to reduce the footprint of VA for the purpose of fulfilling a promise for greater community care access and cutting spending.

If the Committee feels the need to pursue a BRAC process, we believe it is imperative that you consider the recommendations offered by the participants in that round table last month as you proceed with consideration. Unfortunately, this draft bill does not include any changes to the original discussion draft that reflects the concerns raised by the Government Accountability Office (GAO), the Congressional Research Service (CRS), members of the Committee, and veterans' service organization (VSO) stakeholders who participated in that round table.

The fundamental flaw in this proposal is it ignores the most important recommendation/point made by the experts from GAO and CRS. Representatives from GAO specifically outlined the deliberative process that must occur in order to execute an effective BRAC process. The steps in that process include:

1. Establishing clear goals that consider funding and alignment and that reflects the priorities of the Secretary.

2. Developing selection criteria for facilities.

3. Developing a method to effectively estimate costs and savings.

4. Establishing the organizational structure (the Department of Defense created BRAC teams).

5. Utilizing a common analytical framework.

6. Involving audit teams, to include the IG and GAO, to verify data accuracy and reliability.

The key recommendation supporting the entire process outlined above is that VA needs sufficient time to plan the process before executing it. GAO explained that DOD had fully three years before a BRAC Commission was empaneled to consider the infrastructure alignment of DOD. Meanwhile, this bill establishes a process whereby the VA will complete all of its preparatory work within one year from now and the Commission will then submit its final recommendations to Congress within six months following that date (by May 2019), effectively giving VA and the Commission only 18 months to outline the complete realignment of the infrastructure footprint of the Veterans Health Administration (VHA). The draft legislation essentially ignores what GAO identified as the most critical point to ensure success of this process-time. In fact, the most important step of this process as identified by GAO and CRS-establishing goals, setting selection criteria, and developing the cost methodology-has to be completed by March 1, 2018, per the provisions of this draft legislation. Based on the recommendations of GAO, a more reasonable assumption for completion of that phase would be no sooner than 2019, or as far out as 2020 if the DOD model is followed. This bill establishes a timeline that almost certainly will doom VA to failure in this process.

Moreover, this legislation appears to be putting the cart before the horse. We strongly believe that VA should have the opportunity develop and put into operation its integrated health care network before any decisions are made about what the footprint of VA should look like. It makes no sense for VA to make decisions about what its infrastructure alignment will be without first understanding what its capacity to deliver services currently is and how an integrated network must be designed to enhance that capability. Central to that effort is the completion of a thorough market assessment before the network can be fully established and implemented. And yet, this bill presumes that VA will conduct a complete market assessment of the entire VA health care system by this time next year. The VA itself emphasized the near impossibility of that task during the recent round table. GAO and CRS similarly expressed concerns with that expectation. In fact, the VA only recently finished three pilot market assessments that took several months to complete. This bill requires modification to its overall timeline in order to accommodate more time for market assessment if the Committee wants to ensure there is a thorough and effective asset review process. If DOD was given three years to prepare, and the scope of the VA health care system is much larger than the footprint of DOD bases when its BRAC was conducted, the Committee must extend significantly the timeframe established in Section 403 of this proposed bill.

Additionally, the provisions of this legislation that require the market assessment are principally focused on how community care can be better leveraged to expand capacity rather than how the VA itself can build its own internal capacity. Those provisions only seem to affirm the notion that community care is the only viable option where lack of capacity exists. We respectfully disagree with this assertion.

We also have serious concerns that fitting a BRAC model to VA presumes that the nature of the VA health care system is not fundamentally different from the DOD base alignment that was considered during its own BRAC process. This proposal ignores the fact that the DOD BRAC addressed a static military population and simply consolidated and moved units to fit its planned infrastructure alignment. It was relatively easy, though not politically, to simply move military families to new locations to support the force realignment. This fact does not apply to the VA health care system and the population it serves. Decisions to close or downsize a VA medical facility will have a direct impact on the veteran population being actively served in that selected community. That was not a real issue with base, and by extension force, realignment in DOD. This is why the market assessments will be critical to this process.

We wonder what the impact of initiating a BRAC process will be on current major and minor construction activities at VA. When VA initiated its Capital Asset Realignment for Enhanced Services (CARES) process nearly 15 years ago, the most devastating result of this process was the moratorium placed on virtually all construction for a two-year period while the process was conducted. Arguably, the VA's infrastructure is in the condition it is in now because no new resources were invested in the system during that time. Additionally, Congress has compounded that problem every year since that time by woefully underfunding the major and minor construction requirements of VA. Many facilities are now in serious decline simply because they were not upgraded or modernized, and because Congress continues to provide inadequate funding for VA's infrastructure needs, and now many of those facilities face the possibility of closure because of that neglect.

With the establishment of an Asset and Infrastructure Review Account we believe that Congress will simply ignore its responsibility to provide critically-needed funding for ongoing construction projects in an effort to wait for the outcome of the Commission. This is an unacceptable proposition for PVA. Major and minor construction should not be simply put on hold while this BRAC process plays out.

Reviewing the proposed legislation also begs one other important question: why is only VHA being considered in this process and not all of VA, to include facilities of the Veterans Benefits Administration (VBA) and the National Cemetery Administration (NCA)? The individual administrations within VA do not operate separately in their own vacuums. They are interconnected and mutually supporting, particularly with regards to VHA and VBA. Significant changes to the footprint of VHA could obviously have an impact on the other organizations. Moreover, if Congress is serious about doing a thorough asset review, then perhaps all parts of the VA should be included in that discussion.

We appreciate the fact that the Committee recognized the objections raised about the original version of this legislation presented earlier this summer that excluded veterans' service organization involvement in the Commission and has since added the requirement that at least three of the members of the Commission must come from congressionally-chartered VSOs. The perspective that VSOs can bring to this process is frontline experience with VA facilities. With that in mind, it is important that we emphasize that PVA is the only congressionally-chartered VSO with a National Architecture program that is regularly involved in facility design and development at VA. We are the only organization that conducts thorough capacity assessments of the VA, in particular the spinal cord injury/disease (SCI/D) system of care, on an annual basis. We hope that our experience in dealing directly with VA in this capacity will be reflected when staffing for the Commission is considered.

With regards to perceived savings from a BRAC process, it is important to point out that GAO and CRS both confirmed that DOD did not achieve near the projected savings from closure and realignment of its facilities. Moreover, the savings that were generated were not realized until much later following the process. However, we cannot emphasize enough that any savings generated by the asset and infrastructure should be reinvested directly into VA, not sent back to the Treasury simply for deficit reduction. Savings from this process have the potential to generate sorely needed resources to strengthen the VA SCI/D system of care, and other specialized programs. Many existing SCI/D acute care facilities are generally fatigued and in some cases have been deemed unsafe by the VA's own facility condition assessment. In fact, the existing San Diego SCI/D center, one of the highest volume centers in the entire VA health care system, has been deemed unsafe. Design and

construction projects have been identified to correct these essential infrastructure issues yet they remain unfunded.

In addition, the number of beds dedicated to SCI/D long term care on a national level is woefully inadequate. While this BRAC process will almost assuredly focus on areas that can be targeted for closure-a fact of the DOD BRAC process-serious consideration must be given as a part of the process to long term care capacity. While there are some in VA leadership who would like to get VA out of the business of long term care, this is not an acceptable proposition for PVA and our members. The aging SCI/D Veteran population will live longer than past generations and is overwhelming the VA system forcing veterans to live in institutional nursing facilities that are not designed to safely accommodate the special needs of SCI/D veterans. As an example, the VA has invested in the design of the new Dallas SCI/D long term care center which now needs construction funding to begin addressing this pressing need. We wonder what will become of projects such as this while this BRAC process is executed across the VA. Moreover, we do not want to see this process be used as a means to reduce VA's long term care responsibilities.

In the end, quality, accessible health care continues to be the focus for PVA and our partners in The Independent Budget. In order to achieve and sustain that goal, large capital investments must be made where appropriate. We hope that this will be one of the key outcomes of this asset review process.

Mr. Chairman, I would like to thank you again for the opportunity to testify. We look forward to working with this Committee, the VA and our partner stakeholders to ensure that the most thorough and effective process is carried out in order to best position the VA health care system for the future needs of veterans.

Prepared Statement of Carlos Fuentes

Chairman Roe, Ranking Member Walz and members of the House Committee on Veterans' Affairs, on behalf of the women and men of the Veterans of Foreign Wars of the United States (VFW) and its Auxiliary, I thank you for the opportunity to testify on legislation pending before this Committee.

H.R. 2773, to authorize the Secretary of Veterans Affairs to sell Pershing Hall

Pershing Hall has been owned by the Department of Veterans Affairs (VA) since 1991 and is leased as a hotel in Paris, France, until 2097. The VFW agrees that VA should not be in the hotel business, but disposal of the hotel should be more than simply an effort to no longer own the building. The VFW is glad to see that this legislation contains requirements to preserve the history of Pershing Hall and the memory of the brave American service members who fought in World War I.

The VFW would, however, recommend this Committee consider amending this draft legislation to include language that would call for a prospectus that will outline the costs, if any, of breaching the lease agreement and the loss of annual revenue that the current lease provides. With this financial data, VA and this Committee can more clearly see the financial positives and negatives of selling the property.

The VFW also believes that other options must be explored before selling Pershing Hall to a private entity. Since it has been turned into a hotel, the VFW urges this Committee to explore the possibility of transferring the building to the United States Army's Morale, Welfare and Recreation Programs Armed Forces Recreation Centers. The Army's Armed Forces Recreation Centers operate lodging facilities throughout the world, including Korea and Germany.

Draft Legislation, Asset and Infrastructure Review Act of 2017

This legislation would establish a commission to review and amend as needed a VA-generated plan to close, modernize, or realign Veterans Health Administration (VHA) facilities throughout the country. This legislation is based on the Department of Defense's (DOD) Base Realignment and Closure (BRAC) and the Commission on Care's recommendation to "develop and implement a robust strategy for meeting and managing VHA's facility and capital-asset needs." The VFW agrees with the intent of this legislation and has recommendations to improve it.

For more than 100 years, the government's solution to provide health care for our military veterans has been to build, manage and maintain a network of hospitals across the nation. This model allows VA to deliver care at 1,753 facilities, but has left it with more than 5,600 buildings and 34,000 acres, many of which are past

their building lifecycle. Many of these facilities need to be replaced, some need to be disposed of, others need to be expanded, and all of them need to be maintained.

The process to manage this network of facilities is the Strategic Capital Infrastructure Plan (SCIP). SCIP identifies VA's current and projected gaps in access, utilization, condition and safety. It then lists them in order based on the gap's priority. In VA's FY 2018 Budget Submission, the 10-year full implementation plan to close these gaps is estimated to cost $55-$67 billion. The VFW does not foresee a future where VA receives such sums to address all of its capital infrastructure access and safety gaps through its current SCIP process. We agree that VA has an insurmountable capital infrastructure problem, and a dramatic realignment of its assets may help in addressing safety and access gaps to ensure veterans have timely access to the high quality, veteran-centric, and comprehensive health care they have earned and deserve.

The VFW has historically opposed a BRAC-style process for VA medical facilities because the population VA serves is very different from those stationed at and served by military installations. When I was in uniform, the Marine Corps could send me where they wanted, when they wanted, and I had little to no say about it. That is because the nature of our military's obligations and needs change and DOD must realign its assets, including personnel, to defend our nation in an ever-changing security landscape. VA, however, must adapt to the changes in the veterans population and cannot simply require veterans to move from one location to another. Rather, it must continuously adjust capital assets to the changing veteran population. This requires VA to modify, close, or build facilities to adjust to shifts in demand on its health care system.

The SCIP process already addresses the issue of unused or underutilized property, but the process for approving, funding and implementing the plan is what has led to a $67 billion construction backlog. That is why the VFW urges this Committee to require VA to identify barriers in the SCIP process which have led to the backlog and steps needed to ensure a backlog of access and safety infrastructure gaps does not occur after a BRAC-style process is completed. If such barriers and issues are not addressed, the proposed recommendations may not be implemented. For example, a slow and cumbersome construction process impacts VA's ability to complete major construction projects on time and on budget. Another example the VFW has urged this Committee to correct is the congressional authorization process for major medical facility leases. It takes too long for Congress to approve VA leases and veterans are directly impacted by VA's delay in executing such leases. If these issues are not corrected, we will find ourselves in the same or worse situation in the future.

The Commission on Care recommended a workaround to the lease issues that the VFW urges this Committee to consider. It recommended that Congress waive budgetary rules requiring offsets for a period of time and expanding the enhanced-use lease authority to allow VA to enter into needed leases, without accounting for the cost of the entire lease in the first year. However, suspending this offset requirement for a few years will leave VA in the same position it finds itself today if Congress does not find a long-term solution to VA's leasing authority. VA also needs broader authority to enter into enhanced-use leases agreements. Public Law 112–154 reduced VA's authority to allow for only adaptive housing. Returning it to its prior authority will allow VA to lease more of its unused or underutilized property, while still contributing to VA's mission. The VFW is pleased this legislation authorizes VA to use its enhanced-use leases to implement recommendations, but it does not amend VA's overall authority.

The lack of input and buy-in from affected veterans has been the principal reason previous plans to close or realign VA facilities have failed. The VFW is pleased to see this legislation would require the proposed commission to conduct public hearings and seek input from veterans who would be impacted by any commission-made changes to VA's plan. However, this legislation does not require VA to conduct open hearings at medical facilities it plans to realign or close. VA's plan must include local veteran input as well. Including impacted veterans in the process from the beginning ensures more buy-in, if VA takes their concerns and recommendations into account.

This includes the input from veterans who are eligible or enrolled in VA, but do not use VA health care. In the VFW's latest health care survey, we asked veterans who do not use VA to tell us why. Veterans reported having employer-sponsored insurance, not wanting to take appointment slots from veterans who need them more, or problems with access which force them to choose other forms of health care coverage. VA has testified a number of times that it experiences an increase in demand when access to care is improved. If the asset review is successful, VA will improve access to care for veterans in every community. That is why VA must account for

the increase in reliance from veterans who have other forms of health coverage, but would begin to use VA because of the increase in access or life changes such as retirement or employment changes that leave veterans without other forms of health care coverage.

Furthermore, past realignment strategies or plans to close VA medical facilities have not failed because of lack of authority. Veterans in such communities object to closures because the proposed plans create gaps in access to care or do not meet their needs. In order to avoid repeating such mistakes, the VFW urges this Committee to require VA to implement the proposed solutions before eliminating facilities or space. Doing so would ensure veterans do not experience a gap in access or continuation of care. Simply purchasing more care from community care providers is not an acceptable option. For example, VA and Congress cannot expect veterans to wait 10 years for a new facility to be built and think VA is able to close the old facility immediately.

Veterans tell the VFW that they want VA to hire more doctors and build more capacity instead of simply turning to community care to fill the gaps. Through the Veterans Choice Program, we now know that the community is a great force multiplier for VA, but it is not a panacea of access or quality. The VFW is concerned that this legislation requires VA to identify opportunities to fill access gaps by purchasing care through community care providers, but does not require VA to include recommendations to hire more providers, build new facilities, or lease space to correct deficiencies or fill access gaps. Revenue generated from leasing or selling facilities must be reinvested back into expanding access to VA care for veterans.

While the VFW believes that realignment of VA medical facilities must be a naturally occurring process based on the needs of each local community, we understand that past grassroots efforts have failed and that a one-time BRAC-style approach may lead to a better outcome if done correctly. That is why VFW thanks this Committee for including congressionally chartered and membership-based veterans service organizations in the proposed Asset and Infrastructure Review Commission. It is vital that a commission be representative of the veterans' community and those who use the VA health care system the commission is charged with improving. The VFW's health care surveys indicate veterans who use VA health care want VA to hire more doctors and improve access, while those who do not use it are more likely to want to dismantle the system or turn to the private sector rather than fixing issues. It is important that any commission charged with recommending vast changes to a system millions of veterans rely on for their health care has the best interest of veterans in mind—not political or financial motivations.

The VFW is also pleased to see this legislation requires at least one commissioner to have experience with capital asset management for the federal government. Yet, it does not specify whether the commissioner must have experience with VA's capital infrastructure. It is vital that at least one commissioner, and preferably more than one, have experience with the challenges VA faces in addressing its capital infrastructure needs. The VFW has seen previous congressionally established commissions lack the subject matter expertise to properly identify issues that have a direct impact on commission recommendations. If issues with VA's SCIP process are not identified and addressed, recommendations regarding the closure, modernization and realignment of VHA facilities will not be carried out appropriately.

Another lesson learned from previous commissions is that making far-reaching changes envisioned by this legislation takes time. The VFW agrees with comments by the Government Accountability Office, Congressional Research Service and VA at the recent roundtable on this legislation that the current deadlines set in this legislation do not provide sufficient time for VA to develop a well-thought-out plan, the commission to evaluate such plan, nor for VA to implement the final recommendations. The VFW urges this Committee to expand the timelines in the legislation to ensure the process is deliberate and implemented correctly.

Prepared Statement of David J. Wise, Physical Infrastructure Issues

Brian J. Lepore, Director, Defense Capabilities and Management

VA REAL ROPERTY

REALIGNMENT MAY BENEFIT FROM ADOPTING ELEMENTS OF DEFENSE BASE REALIGNMENT AND CLOSURE PROCESS, PROVIDED PROCESS CHALLENGES ARE ADDRESSED

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

We are pleased to be here today to discuss our work related to the Department of Veterans Affairs' (VA) efforts to align its medical facilities and services, as well as our work on the Department of Defense's (DOD) military Base Realignment and Closure (BRAC) process. These efforts are both relevant to challenges the federal government faces in real property management.

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 included 6,091 federally owned buildings and 1,586 leased buildings. However, in recent decades, the veteran population and preferences have shifted. VA has recognized this shift 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.[1] In 2003, GAO placed federal real property management-including management of VA real property-on its High Risk List due to long-standing challenges, such as effectively disposing of excess and underutilized federal property.[2]

DOD has repeatedly applied the BRAC process to reduce the amount of unneeded property that it owns and leases. DOD has undergone five BRAC rounds since 1988 as a means of reducing excess infrastructure and realigning bases to meet changing force structure needs. The most recent BRAC round in 2005 also provided opportunities for furthering transformation and fostering jointness. As a result of these rounds, DOD reported that it had reduced its domestic infrastructure and transferred hundreds of thousands of acres of unneeded property to other federal and nonfederal entities. DOD data show that the department generated an estimated $28.9 billion in net savings or cost avoidances from the prior four BRAC rounds through fiscal year 2003 and expects to save about $7 billion each year thereafter. Regarding the 2005 BRAC round, we estimated that DOD saved about $15.2 billion from fiscal years 2006 through 2011 with an annual recurring savings of $3.8 billion beginning in fiscal year 2012. These savings reflect money that could be applied to other higher priority defense needs as well as savings from what DOD estimated it would likely have spent to operate military installations had they remained open.

Our testimony today is based on our April 2017 report examining VA's efforts to align its facilities with veterans' needs, and on numerous GAO reports related to the BRAC process as summarized in June 2011 and March 2012 testimonies.[3] Today's testimony addresses (1) the factors that affect VA's facility alignment and the extent to which VA's capital-planning process facilitates the alignment of facilities with the veterans' population, and (2) the key elements and challenges affecting DOD and the Commission in BRAC 2005. For our April 2017 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. Additional information on our scope and methodology is available in our April report. Detailed information on our scope and methodologies for our BRAC work can be found in the published products, which are cited throughout this testimony. The work on which this testimony is based was conducted in accordance with generally accepted government auditing

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[1] 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.

[2] See GAO, High-Risk Series: Federal Real Property, GAO 03 122 (Washington, D.C.: January 2003).

[3] See GAO, VA Real Property: VA Should Improve Its Efforts to Align Facilities with Veterans' Needs, GAO 17 349 (Washington, D.C.: Apr. 5, 2017), Federal Real Property: Proposed Civilian Board Could Address Disposal of Unneeded Facilities, GAO 11 704T (Washington, D.C.: June. 9, 2011), and Military Base Realignments and Closures: Key Factors Contributing to BRAC 2005 Results, GAO 12 513T (Washington, D.C.: Mar. 8, 2012).

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.

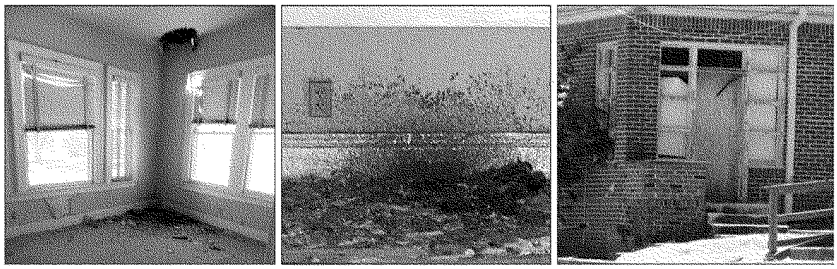
VA's Efforts to Align its Facilities Are Affected by Several Factors and Are Impeded by Limitations in Its Capital-planning Processes

Facility Alignment Is Challenged by Shifting Veterans' Populations, Evolving Care Standards, Aging Infrastructure, and Limited Stakeholder Involvement

Geographic shifts in the veterans' population, changes in health care delivery, an aging infrastructure, and limited stakeholder involvement affect VA's efforts to align its services and real property portfolio to meet the needs of veterans. For example, there has been a shift over time from inpatient to outpatient care. This shift 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 that 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 DOD and the Department of the Interior. In some instances, it may be more expensive to renovate than to demolish and rebuild outdated facilities. In other cases, however, there may not be an option to demolish if these buildings are designated as historic. For example, planning officials at four medical facilities in our review told us that state historic preservation efforts prevented the VA 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



Interior damage of Kerrville Medical Center. | Portions of the ceiling have collapsed, spraying debris on to the floors and walls. | Exterior view of the building shows broken windows and missing bricks.

Source: GAO. | GAO-18-189T

Note: Kerrville VA Medical Center, Kerrville, Texas: These pictures show a dwelling formerly used for medical staff housing that has been designated as a historic building. The outside of the building shows broken windows, missing bricks, and gutters that have nearly detached from the building. On the inside, portions of the ceiling have collapsed, spraying debris onto the floors and walls.

VA has also 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 found that VA has not consistently engaged with stakeholders, and, in some cases, this inconsistency resulted in adversarial relationships that reduced VA's ability to better align facilities with the needs of the veteran population.

In our April 2017 report, we recommended that VA improve stakeholder communication guidance and evaluate its efforts. VA agreed with our recommendations and outlined a plan to implement them.

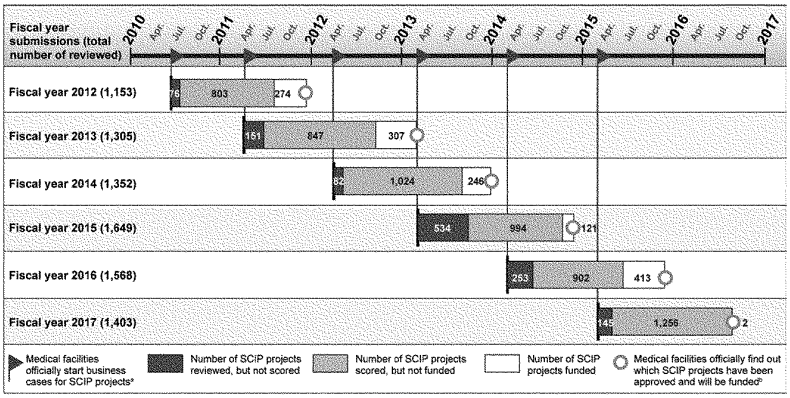
Limitations in VA's Capital-planning Processes Impede Its Alignment of Facilities

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. [4]

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's SCIP submissions. [5] (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.

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



Source: GAO analysis of Department of Veterans Affairs information. | GAO-18-189T

(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

[4] 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.

Separately, 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.

[5] 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).

day of the fiscal year for that project's submission because such projects 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 VA's 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 time frame 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.[6] 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 VA's 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.[7] VA concurred with the recommendation to the extent the limitations were within its control. While VA has taken some actions, the recommendation remains open.

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 medical facility. VA has estimated the entire process to create plans for VISNs and facilities to cost $108 million when fully complete.[8] 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 (1) VA obligated about $10.1 billion to purchase care from non-VA providers in fiscal year 2015 and (2) 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.[9] 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.[10]

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, to either (1) discontinue the development of VAIP's facility master plans or (2) address the limitations of VAIP's facility master plans.[11] VA concurred with the recommendation, and in August 2017, VA noted that it has discontinued its VAIP facility master plans while VA pursues a national realignment strategy, after which

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[6] See GAO, Standards for Internal Control in the Federal Government, GAO 14 704G (Washington, D.C.: September 2014).

[7] See GAO 17 349.

[8] VA organizes its system of care into regional networks (VISNs), which are responsible for coordination and oversight of all administrative and clinical activities within the VISN's 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.

[9] 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, among other programs. 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.

[10] See Office of Management and Budget, Circular No. A–11: Preparation, Submission, and Execution of the Budget, July 2016.

[11] See GAO 17 349.

it plans to adjust its future facility master plans to incorporate pertinent information, including care in the community realignment opportunities.

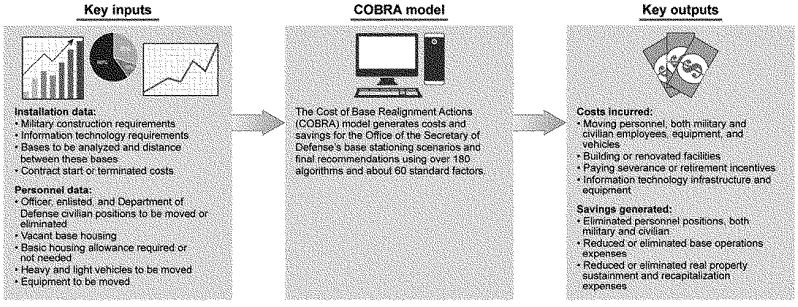
Key Elements and Challenges Affecting DOD and the Commission in BRAC 2005

Key Elements That DOD Used to Develop Its 2005 BRAC Recommendations That Could Benefit VA Asset and Infrastructure Review

As Congress evaluates proposed legislation for disposing of or realigning VA property, it may wish to consider seven elements DOD relied on as it developed its recommendations for the BRAC Commission. [12]

- **Establish goals for the process.** The Secretary of Defense emphasized the importance of transforming the military to make it more efficient as part of the 2005 BRAC round. Other goals for the 2005 BRAC process included fostering jointness among the four military services, reducing excess infrastructure, and producing savings. Prior rounds focused more on reducing excess infrastructure and producing savings.
- **Develop criteria for evaluating closures and realignments.** DOD proposed selection criteria, which were made available for public comment via the Federal Register. Ultimately, Congress enacted the final BRAC selection criteria in law with minor modification and specified that four selection criteria, known as the "military value criteria," were to be given priority in developing closure and realignment recommendations. [13] Further, Congress required that the Secretary of Defense develop and submit to Congress a force structure plan that described the estimated size of major military units needed to address probable threats to national security for the 20-year period beginning in 2005, along with a comprehensive inventory of global military installations. [14] In authorizing the 2005 BRAC round, Congress specified that the Secretary of Defense publish a list of recommendations for the closure and realignment of military installations inside the United States based on the statutorily-required 20-year force structure plan and infrastructure inventory, and on the final selection criteria.
- **Estimate costs and savings to implement closure and realignment recommendations.** To address the cost and savings criteria, DOD developed and used the Cost of Base Realignment Actions (COBRA) model, a quantitative tool that DOD has used since the 1988 BRAC round to provide consistency in potential cost, savings, and return-on-investment estimates for closure and realignment options. We found the COBRA model to be a generally reasonable estimator for comparing potential costs and savings among alternatives. (See fig. 3.)

Figure 3: Key Inputs and Outputs of the Cost of Base Realignment Actions (COBRA) model



Source: GAO analysis of DOD information. | GAO-18-186T

[12] After DOD selected its recommendations, it submitted them to the BRAC Commission, which performed an independent review and analysis of DOD's recommendations. The Commission could approve, modify, reject, or add closure and realignment recommendations.

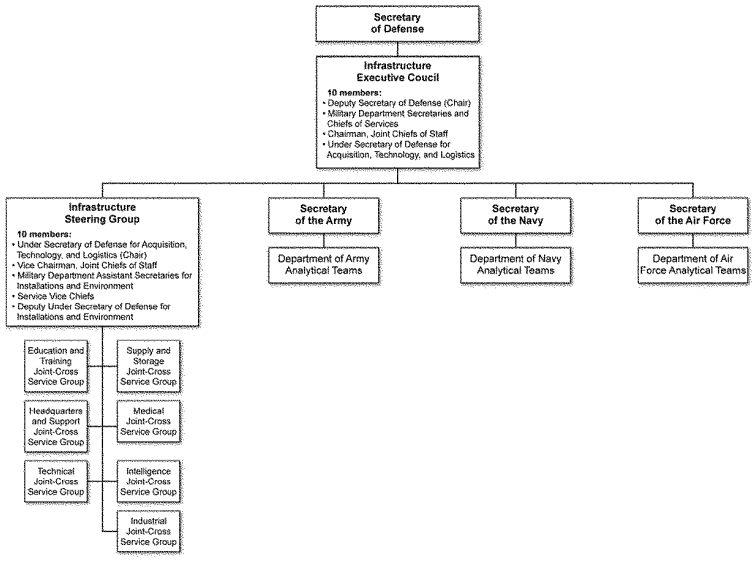
[13] Section 2832 of the Ronald W. Reagan National Defense Authorization Act for Fiscal Year 2005, Pub. L. No. 108–375 (2004).

[14] Section 3001 of the National Defense Authorization Act for Fiscal Year 2002, Pub. L. No.107–107 (2001), amended the Defense Base Closure and Realignment Act of 1990, Pub. L. No. 101–510 (1990), to, among other things, require DOD to develop a 20-year force structure plan as the basis for its 2005 BRAC analysis to include the probable end strength levels and major military force units needed to meet the probable threats identified by the Secretary of Defense.

As with any model, the quality of the output from COBRA was a direct function of the data DOD included in the model. Also, DOD's COBRA model relied to a large extent on standard factors and averages and did not represent budget quality estimates that were developed once BRAC decisions were made and detailed implementation plans were developed. Nonetheless, the financial information provided important input into the selection process as decision makers weighed the financial implications-along with military value criteria and other considerations-in arriving at final decisions about the suitability of various closure and realignment options.

- **Establish an organizational structure.** The Office of the Secretary of Defense emphasized the need for joint cross-service groups to analyze common business-oriented functions. For the 2005 BRAC round, as for the 1993 and 1995 rounds, these joint cross-service groups performed analyses and developed closure and realignment options in addition to those developed by the military departments. Our evaluation of DOD's 1995 BRAC round found that few cross-service recommendations were made, in part because of the lack of high-level leadership to encourage consolidations across the departments' functions. In the 1995 BRAC round, the joint cross-service groups submitted options through the military services for approval, but few were approved.[15] The number of approved recommendations that the joint cross-service groups developed significantly increased in the 2005 BRAC round. This increase was, in part, because high-level leadership ensured that the options were approved not by the military departments but rather by a DOD senior-level group, known as the Infrastructure Steering Group. As shown in figure 4, the Infrastructure Steering Group was placed organizationally on par with the military departments.

Figure 4: Department of Defense's (DOD) Base Realignment and Closure (BRAC) Leadership Structure



Source: Department of Defense. | GAO-18-189T

- **Establish a common analytical framework.** To ensure that the selection criteria were consistently applied, the Office of the Secretary of Defense, the military departments, and the seven joint cross-service groups first performed a capacity analysis of facilities and functions. Before developing the candidate recommendations, DOD's capacity analysis relied on data calls to hundreds of locations to obtain certified data to assess such factors as maximum potential capacity, current capacity, current usage, and excess capacity. Then, the military departments and joint cross-service groups performed a military value analysis for the facilities and functions based on primary military value criteria, which

[15] GAO, Military Bases: Lessons Learned From Prior Base Closure Rounds, GAO/NSIAD 97 151 (Washington, D.C.: July 25, 1997).

included a facility's or function's current and future mission capabilities, physical condition, ability to accommodate future needs, and cost of operations.

- **Develop BRAC oversight mechanisms to improve accountability for implementation.** In the 2005 BRAC round, the Office of the Secretary of Defense for the first time required the military departments to develop business plans to better inform the Office of the Secretary of Defense of the status of implementation and financial details for each of the BRAC 2005 recommendations. These business plans included: (1) information such as a listing of all actions needed to implement each recommendation; (2) schedules for personnel relocations between installations; and (3) updated cost and savings estimates by DOD based on current information. This approach permitted senior-level intervention if warranted to ensure completion of the BRAC recommendations by the statutory completion date.
- **Involve the audit community to better ensure data accuracy.** The DOD Inspector General and military department audit agencies played key roles in identifying data limitations, pointing out needed corrections, and improving the accuracy of the data used in the process. In their oversight roles, the audit organizations, which had access to relevant information and officials as the process evolved, helped to improve the accuracy of the data used in the BRAC process and thus strengthened the quality and integrity of the data used to develop closure and realignment recommendations. For example, the auditors worked to ensure certified information was used for BRAC analysis and reviewed other facets of the process, including the various internal control plans, the COBRA model, and other modeling and analytical tools that were used in the development of recommendations.

Key Challenges Affecting DOD and the Commission in BRAC 2005

We identified two key challenges that affected DOD's implementation of BRAC 2005 and would need to be addressed for VA to adopt a BRAC-like process for its asset and infrastructure review.

- **Some transformational-type BRAC recommendations required sustained senior leadership attention and a high level of coordination among many stakeholders to complete by the required date.** Implementation of some transformational BRAC recommendations-especially those where a multitude of organizations had roles to play to ensure the achievement of the goals of the recommendation-illustrated the need to involve key stakeholders and effective planning. For example, the Defense Logistics Agency committed sustained high-level leadership and included relevant stakeholders to address implementation challenges faced with the potential for disruptions to depot operations during implementation of the BRAC consolidation recommendation.[16] To implement the BRAC recommendations, the agency had to develop strategic agreements with the services that ensured that all stakeholders agreed on its plans for implementation, and had to address certain human capital and information technology challenges.
- **Large number of actions and interdependent recommendations complicated the implementation process.** The large number and variety of BRAC actions presented challenges during implementation. The BRAC 2005 round had more individual actions (813) than the four prior rounds combined (387). The executive staff of the Commission told us that it was more difficult to assess the costs and the amount of time for the savings to offset the implementation costs since many of the recommendations contained multiple interdependent actions, all of which needed to be reviewed. Specifically, many of the BRAC 2005 recommendations were interdependent and had to be completed in a sequential fashion within the statutory implementation period. In cases where interdependent recommendations required multiple relocations of large numbers of personnel, delays in completing one BRAC recommendation had a cascading effect on the implementation of other recommendations. Specifically, DOD had to synchronize the relocations of over 123,000 people with about $24.7 billion in new construction or renovation. Commission officials told us that in prior BRAC rounds each base was handled by a single integrated recommendation. However, in BRAC 2005, many installations were simultaneously affected by multiple interconnected BRAC recommendations. Given the complexity of interdependent recommendations, the Office of the Secretary of Defense required the

[16] GAO, Military Base Realignments and Closures: DOD Needs to Update Savings Estimates and Continue to Address Challenges in Consolidating Supply-Related Functions at Depot Maintenance Locations, GAO 09 703 (Washington, D.C.: July 9, 2009).

military departments and defense agencies to provide periodic updates on implementation challenges and progress.

Chairman Roe, Ranking Member Walz, and Members of the Committee, this concludes our prepared statement. We are happy to answer any questions related to our work on VA's efforts to align its medical facilities and services or on DOD's BRAC process.

GAO Contact and Staff Acknowledgments

If you or your staff members have any questions concerning this testimony, please contact David Wise at (202) 512–2834 or wised@gao.gov regarding federal real property, or Brian Lepore at (202) 512–4523 or leporeb@gao.gov regarding the BRAC process. 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 Keith Cunningham, Assistant Director; Gina Hoffman, Assistant Director; Tracy Barnes; Jeff Mayhew; Kevin Newak; Richard Powelson; Malika Rice; Jodie Sandel; Eric Schwab; Amelia M. Weathers; and Crystal Wesco.

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Prepared Statement of Regan L. Crump, MSN, DrPH

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) plans for modernizing our health care system and infrastructure, and optimizing the care we provide for Veterans through high-performing integrated networks. The Committee recently added to today's agenda H.R. 2773, to authorize the Secretary of Veterans Affairs to sell the property known as Pershing Hall. VA has not had sufficient time to include views on this bill in this statement, but will be glad to follow up with the Committee.

The draft legislative text in the Asset, Infrastructure and Review Act of 2017 calls for VA to assess its health care markets nationwide and determine ways to optimize its care and services for Veterans, and then submit its recommendations regarding closure, modernization, or realignment of its facilities to an appointed Commission. The draft legislation provides that the Commission may change recommendations provided by the Secretary prior to submitting its written report of findings and conclusions to the President. If the President approves the Commission's final recommendations, they are presented to Congress to be considered through a resolution and voting process.

The Department appreciates the Committee for its recognition and commitment to delivering quality care to our Veterans. The draft bill includes many thoughtful features that could serve as useful benchmarks for the critical market analysis needed to guide focused, localized and objective data for decision-making. VA would like to follow up with the Committee to provide more in-depth comments and technical assistance. As for the Commission, VA defers to Congress for a process it would establish for its own consideration of recommendations.

As the Secretary has emphasized, VA is moving forward with more efficient and agile management of VA's medical care facilities to match where Veterans live. This is a critical element of VA's modernization. In concert with the draft legislation, I would like to discuss how VA is moving forward to improve our services and infrastructure, and highlight some opportunities that will enhance VA's ability to serve our Nation's Veterans.

VA Health Care System

VA's mission is distinct from other Federal agencies in that we operate the Nation's largest integrated health care system, with more than 1,500 health service delivery sites, including hospitals, clinics, community-living centers, and residential treatment facilities. Additionally, VA administers a variety of benefits and other services, and operates 135 national cemeteries nationwide.

One aspect of VA that distinguishes us from large private-sector health systems is that the average age of VA-owned buildings is approaching 60 years.

Managing infrastructure of that age poses complex challenges and requires a significant amount of resources. It requires a great deal of internal and external coordination and collaboration to modernize a system of that nature, while adjusting to constantly changing Veteran demographics across the country.

VA Capital Infrastructure

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 identified 430 individual vacant buildings totaling 5.9 million gross square feet 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 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 support VA's mission. Since June 2017, we have repurposed or disposed of 110 buildings, and VA is on track to meet the goal of initiating disposal or reuse actions for all 430 buildings by June 2019, which was our

original goal. VA will review the approximately 780 underutilized buildings in VA's inventory to determine if additional efficiencies can be identified to be reinvested in Veterans' services.

Modernization and Foundational Services

The Secretary has made a commitment to modernize our systems and infrastructure by focusing on primary care and VA's other foundational services and the facilities where such services are delivered. By foundational, I refer to those services that have been tailored to meet the needs of the men and women who have served our country, many of whom have experienced the physical and mental wounds of war. Such services often cannot be provided in the community with the level of quality, understanding, and intensity that Veterans receive when these services are provided by VA. Along with these foundational services, VA plans to ensure that Veterans continue to have the ability to receive those services contained in the benefits package available under applicable law.

Commission on Care

VA agreed with the Commission on Care observation that VA should determine the optimal mix of health care services to meet Veteran needs at the market level, before realigning its infrastructure to leverage non-VA health care resources that are available in local communities to complement VA care. VA also agreed with the Commission's assessment that VA would need broader authorities and tools to optimize VA's capital assets.

Way Forward - Market Area Optimization for High Performing Networks

In response to the Commission on Care, and the Fiscal Year (FY) 2015 Appropriations Bill requiring a National Realignment Strategy, VA has developed a methodology to objectively assess its health care demand and service-delivery capacity in each of our health care system's 96 markets. The methodology is a rigorous, analytic approach developed and validated through the recent pilots. We believe this data-driven eight-step methodology is sound and reflects a population-based approach to improving the health and wellbeing of our enrolled Veterans.

The goal of future assessments will be to modernize VA's health care system, using this data-driven approach for matching local capacity to local demand and to create a modern, high-performing integrated health care network in each market, to better serve Veterans now and in the future. The methodology assesses current and future Veteran demand for medical care, and all the capabilities of local VA providers, Department of Defense (DoD) treatment facilities, academic affiliates, Federally Qualified Health Centers, other Federal, State, and local partners, and telehealth resources. We recently awarded a contract to secure private-sector experts to support our market-assessment teams led by Veterans Integrated Service Networks. However, the contract award is now the subject of ongoing legal action which delays implementation of market assessments until at least December 1, 2017.

The intended outcome of these assessments, once started, is a plan for a high-performing health care network in each market. These networks will be well-connected, comprehensive, coalitions led by experienced VA managers who will coordinate VA health care services, complimented where appropriate by DoD treatment facilities, academic affiliates, Federally Qualified Health Centers, and other suitable community providers. We will also continue to fulfill our research, health professional training, and emergency preparedness missions.

Achieving high performing networks may require significant capital investments, clinical service-line adjustments, process improvements, some targeted divestments, robust care coordination, and smart use of strategic partnerships. The plans we pursue will undoubtedly require the continued support of Congress, Veteran Service Organizations (VSOs), and other stakeholders to ensure success.

Expanded Strategic Partnerships

In addition to VA's current authorities to manage and reconfigure its vast real property portfolio, VA will continue to explore ways to leverage and establish additional capability and efficiencies with other Federal agencies, such as DoD and the General Services Administration, as well as capabilities and efficiencies with private-sector partners. Improved authorities to pursue joint facilities with DoD, as well as with private-sector, non-profit partners through construction and leasing actions, will provide greater opportunities for VA to deliver 21st Century care and services to Veterans in state-of-the-art facilities, nationwide.

DoD is an extremely important partner for VA because, they already care for over 2 million Veterans, including Veterans who are military retirees under the TRICARE program, in addition to all the brave men and women who will be tomor-

row's Veterans. We welcome legislative flexibilities to work with DoD and other partners in a manner consistent with the President's interagency management and agency reform agenda, and encourage enhanced continuity of care, joint purchasing, and shared capital investments.

Support from Congress

In order to modernize the health care system, 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, will increase the Department's flexibility to meet Veteran's needs. VA included proposals to: (1) increase the threshold for minor construction projects from $10 million to $20 million; (2) modify Title 38 to eliminate impediments to joint facility projects with DoD and other Federal agencies; and (3) expand VA's Enhanced Use Lease authority to afford VA improved capabilities to manage and leverage its real property portfolio. Enactment of these authorities will be critical to modernizing VA's health care system in accordance with the demands of younger Veterans and changes needed in all health care systems across the country. We must remain perpetually agile, so we can continually adapt to the changing needs of the Veterans we are privileged to serve.

Conclusion

We welcome and need the support of Congress, VSOs, State and local departments of Veterans Affairs, other Federal agencies, and the media. Working together, and with the necessary flexibilities to modernize, we will be able to achieve the optimal mix of services and infrastructure needed to provide high-quality care, readily accessible services, and outstanding benefits for our Nation's Veterans. The Department will keep the Committee informed as progress is made and as barriers are encountered.

Mr. Chairman, Ranking Member, and Members of the Committee, this concludes my statement. Thank you for the opportunity to testify before the Committee today.

Mr. Sullivan and I are here to learn all that we can, and we are happy to respond to any questions you may have.

STATEMENT FOR THE RECORD

CONCERNED VETERANS FOR AMERICA (CVA)

Draft Legislation - The Asset and Infrastructure Review Act of 2017

A bill to establish an independent commission to review and re-align the Department of Veterans Affairs's current infrastructure.

The Department of Veterans Affairs (VA) devotes large amounts of resources to maintain aging and excess infrastructure across the country. This had led to funds that could have been spent directly in support of our veterans being wasted on the upkeep of buildings and land that should have been sold, downsized, or re-purposed for other uses long ago. Additionally, the VA's current infrastructure footprint was designed to serve a veteran population that is much different from the current one and which will not serve the much smaller and more dispersed veteran population of the future. It is for these reasons that VA Secretaries under Presidents Bush, Obama, and Trump have all stated the need for a comprehensive asset review and re-alignment. Concerned Veterans for America has long advocated for this type of legislation and we feel it is essential to ensuring that the VA is best equipped to serve our veterans now and in the future.

Concerned Veterans for America supports this legislation.

HR 2773 - To authorize the Secretary of Veterans Affairs to sell Pershing Hall

A bill to authorize the Secretary of Veterans Affairs to sell Pershing Hall for fair market value

The VA should have the ability to sell Pershing Hall in Paris, France in order to direct resources to other more critical programs.

Concerned Veterans for America supports this legislation.

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