STATEMENT OF

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BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

VA's INFRASTRUCTURE & PENDING MAJOR MEDICAL FACILITY PROJECTS AND LEASE AUTHORIZATION REQUESTS

WASHINGTON, D.C. MAY 11, 2006

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the 2.4 million men and women of the Veterans of Foreign Wars of the U.S. (VFW), this nation's largest combat veterans organization, I would like to thank you for the opportunity to testify today on rightsizing the Department of Veterans Affairs' (VA) infrastructure and its major medical facility project and least authorization requests.

Over the last few years, construction projects and leasing arrangements have been overshadowed by the Capital Assets Realignment for Enhanced Services (CARES) process. CARES, which aims to reorganize the VA health care system to properly plan for the future, and, in turn, realize improved health care service for veterans, has been a long and difficult process.

We will continue to support CARES as long as VA returns to its primary emphasis and intent: the "ES" portion of CARES. We accept that locations and missions of some VA facilities may need to change to improve veterans' access, to allow more resources to be devoted to medical care rather than to the maintenance of old buildings, and to accommodate more modern methods of health-care delivery. Accordingly, we concur with VA's plans to proceed with the feasibility studies of the remaining 18 facilities contained in the Secretary's decision document. We note that those processes are moving forward on the local level with establishment of local advisory committees and public hearings, allowing the veterans, who are stakeholders in this complex process, to have a voice. We support this transparent approach to public policy, and intend to remain active in it.

In July 2004, the previous VA Secretary testified before the Subcommittee on Health of the House Veterans' Affairs Committee. He stated that CARES "reflects a need for additional investments of approximately $1 billion per year for the next 5 years to modernize VA's medical infrastructure and enhance veterans' access to care."

Using that as a baseline, and accounting for the 18 CARES-related projects being assessed, the IB calls for $860 million to be allocated for CARES projects. We must keep in mind, however, that as projects advance and as ground is broken, funding levels will need to be increased dramatically.

Over the last few years, the funding for major construction has ebbed. This moratorium was caused by the planning of the CARES process. There was much political resistance to funding any projects before the planning process took place. Now that it has occurred, it is time to move forward, and advance this important plan.

Delays cost money. With the rate of construction inflation roughly 9% nationwide (and regionally as high as 35% in some parts of the South), pushing these projects further into the future will only increase the amount of money Congress will need to provide to maintain this nation's commitment to veterans' health care.

Under the major construction account, we are calling for a total investment of $1.447 billion. Of particular importance on that list is the funding for seismic corrections. Currently, 890 of VA's 5,300 buildings have been deemed at "significant" seismic risk, and 73 VHA buildings are at "exceptionally high risk" of catastrophic collapse or major damage. We understand that the list of major construction priorities that VA has provided to Congress includes the seven facilities most at risk of damage. Accordingly, this will increase VA's need for construction funding. This is a chance to be proactive and fix a problem before the health and safety of VA's patients and workers is further compromised.

We also call for funding for an architectural master plan. Without this plan, the benefits of CARES will be jeopardized by hasty and shortsighted construction planning. Such a master plan will also go a long ways in determining where and when leasing arrangements will be the most advantageous.

Currently VA plans construction in a reactive manner—i.e., first funding the project then fitting it on the site. Furthermore, there is no planning process that addresses multiple projects; each project is planned individually. "Big picture" design is critical so that a succession of small projects don't "paint" the facility into the proverbial corner. If all projects are not simultaneously planned, for example, the first project may be built in the best site for the second project. The development of master plans will prevent shortsighted construction that restricts, rather than expands, future options. As the cost of construction rises with inflation, the importance of optimal planning becomes paramount.

We believe that architectural master planning will also provide a mechanism to address the three critical programs that the CARES study omitted. Specifically, these are long-term care, severe mental illness, and domiciliary care. These programs should be addressed as quickly as possible.

For Minor Construction we are calling for $505 million in funding. The funds for minor construction comprise construction projects costing less than $7 million. This appropriation includes

funding for the National Cemetery Administration, the Veterans Benefits Administration, and the Inspector General.

With the reticence over the last few years to provide construction funding, the amount appropriated for maintenance has lagged far behind what has been needed. Price-Waterhouse, following standard industry practices, has recommended that VA spend at least 2-4% of the value of its building for nonrecurring maintenance. These small projects, such as replacing a roof or improving the fire alarm system, are necessary for the safety of patients, but also to maintain the integrity of the building so that it is viable for its entire lifespan. Accordingly, VA should spend no less than $1.6 billion for nonrecurring maintenance in FY 2007. Unfortunately, the Administration has only allocated $514 million for maintenance, which will only make the already backlogged maintenance lists grow.

Further, because maintenance comes out the medical care account, not the construction budget, much of the funding for the last few years has been used to provide medical care. VA needs to cover deferred maintenance. In fact, according to VA's own assessment, which is conducted on three-year cycles, the investment necessary to bring all facilities currently rated "D" or "F" up to an acceptable level is $4.9 billion. There should not be a choice between fixing a roof and buying medical supplies. It is Congress' job to allocate properly funding for both.

Funding for maintenance is allocated to the VISN level using the VERA methodology. While this moves the money to the growing demand for veterans' health care, it tends to move the money away from the oldest capital structures, which need the most maintenance. It also increases the tendency in some VISNs to use maintenance money to address shortfalls in medical care funding.

It is also important that VA recapitalize their infrastructure beyond nonrecurring maintenance. Properly reinvesting in facilities extends their useable life, and saves costs over the long run. Both Price-Waterhouse and the American Society of Hospital Engineers say that a 35 to 50-year recapitalization rate is required for VA facilities. Of note, most hospitals rely on a 25-year or less rate of recapitalization. VA traditionally has a historically low rate of recapitalization. From FY 1996-2001, for example, it was just a paltry 0.64% of VA's total plant replacement value. To overcome this shortfall, a minimum of 5-8% investment of plant replacement value is necessary to maintain a healthy infrastructure. If not improved, veterans could be receiving care in potentially unsafe, dysfunctional settings. Congress must ensure that VA has adequate funding to ensure the life of its infrastructure.

We thank you for allowing us to testify today, and we would be happy to answer any questions that you or the committee may have.