H.R. 1720, H.R. 116, H.R. 2307, AND H.R. 2349

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTH CONGRESS

FIRST SESSION

JUNE 11, 2003

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WEDNESDAY, JUNE 11, 2003

U.S. HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC

The committee met, pursuant to notice, at 2:02 p.m., in room 334, Cannon House Office Building, Hon. Rob Simmons (chairman of the subcommittee) presiding.

Present: Representatives Simmons, Beauprez, Rodriguez, Snyder, Strickland, Berkley, Boozman, and Brown-Waite.

OPENING STATEMENT OF CHAIRMAN SIMMONS

Mr. SIMMONS. The subcommittee will come to order. If somebody could secure the door. I welcome everybody this afternoon.

And before we move on, without objection, I'd like to enter into the record several statements, one from Congressman David Hobson of Ohio; also, Congressman Joel Hefley of Colorado; Congressman Solomon Ortiz of Texas; Congresswoman Deborah Pryce of Ohio; and Congressman Lane Evans, our Ranking Member of the committee. Without objection, those statements will be entered into the record.

[The prepared statement of Congressman Evans appears on p. 58.]

[The prepared statement of Congressman Hobson appears on p. 62.]

[The prepared statement of Congressman Hefley appears on p. 64.]

[The prepared statement of Congressman Ortiz appears on p. 77.]

[The prepared statement of Congresswoman Pryce appears on p. 78.]

Mr. SIMMONS. The purpose of today's legislative hearing is to authorize the Secretary of Veterans' Affairs to carry out several major construction projects to improve, renovate, and update patient care facilities at various VA medical centers. We will be discussing four bills. And the bill summaries are in the members' packets. It would be H.R. 1720, H.R. 116, H.R. 2349, and H.R. 2307. And I would ask the members that they refer to their packages for those summaries.

I think we all know that the physical infrastructure of the VA health care system is one of the largest in the U.S. Government, if not the largest, with over 4700 buildings and thousands and thousands of acres of property. These buildings, many of which were built 50 years ago or more, are now substandard. And the se-

verity of this problem extends to those buildings in earthquake zones that we are afraid are in danger of collapsing. And this has actually happened. I believe out in California, we had a couple of collapses. So this is a serious matter.

I think it's painfully clear that VA's investment in health care facilities infrastructure has not been satisfactory in recent years. And while many members of this committee support the concept of the VA CARES system, or Capital Asset Realignment for Enhancement Services system, there are concerns that the continued extension of the deadline of the CARES system is creating present for those facilities that I think many of us can agree need the investment and need the investment now.

Some of the bills before us address specific properties. One of the bills before us addresses a general authority to the Secretary of Veterans Affairs to authorize him to make decisions and move forward on some of these projects.

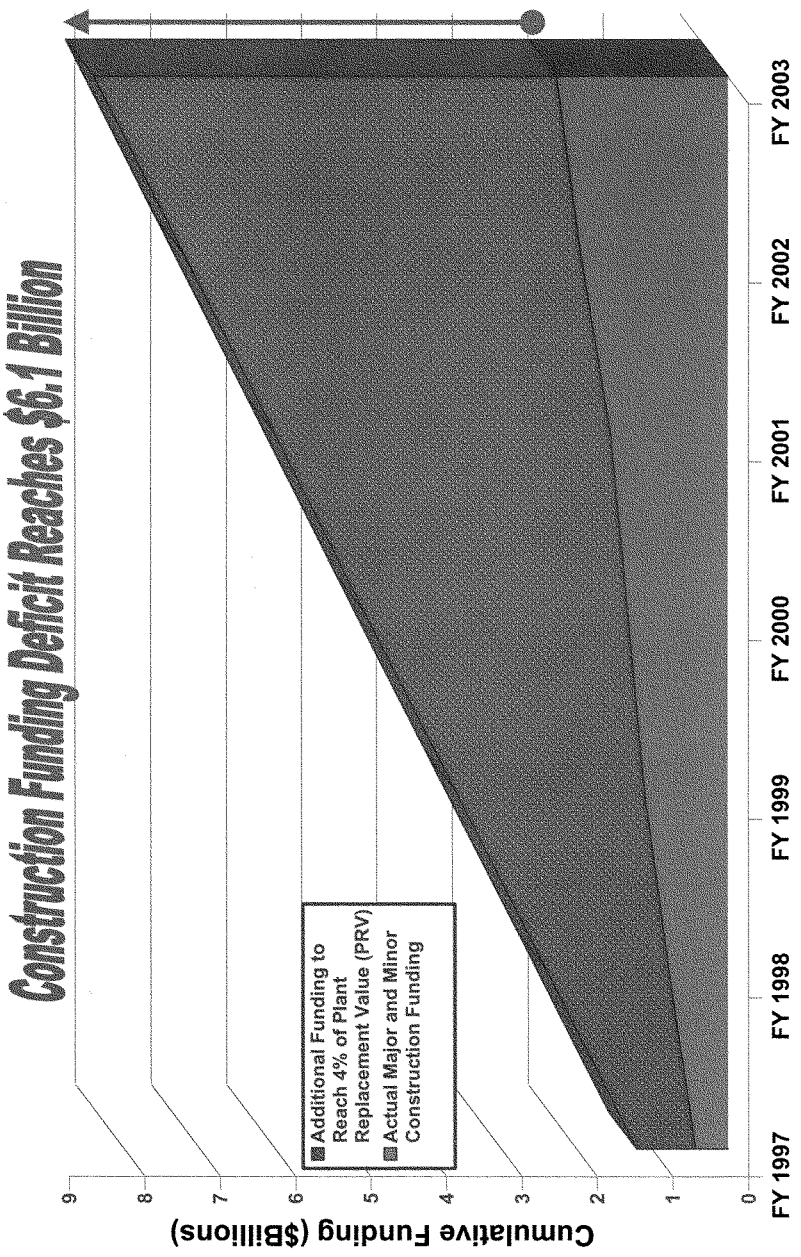
In particular, I note for the record that the West Haven VA medical facility in my state is a magnificent edifice from a distance as one drives by I–95. The sign is on the top. It stands on a prominent hill. And it's very impressive. But when you get inside, lo and behold, the cracks, the peeling paint, the difficulties of cluttered, dingy, and some would even say seedy spaces, beg the argument that we need to do something about that facility.

And consider this. They are a primary affiliate with Yale Medical School, one of the premiere medical schools in America. And so I think it's important that we address these issues, not just in my district or in my state, but elsewhere across the country.

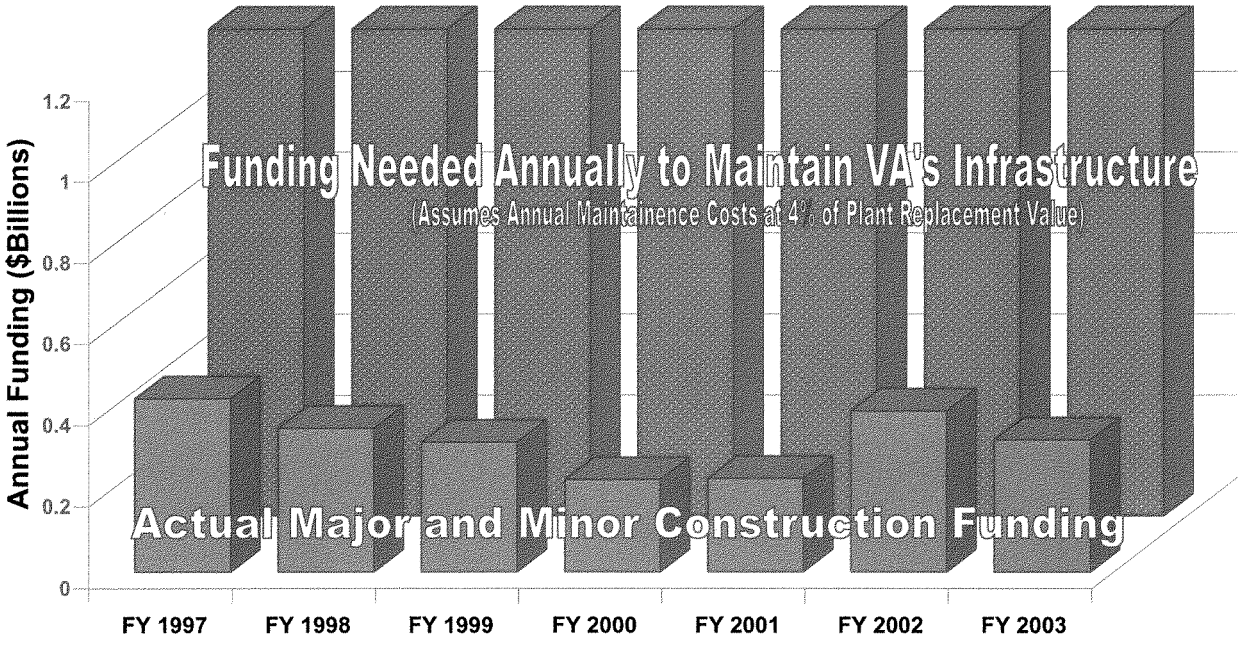
If you refer to the charts that are set up on the side of the chamber, you will notice one chart that says, "Construction Funding Deficit Reaches 6.1 Billion." And the green on the chart indicates the actual major and minor construction funding from FY '97 through '03. The orange reflects additional funding to reach a 4 percent of plant replacement value. That additional funding has not been there.

A different way of looking at it is on the second chart that has two columns—one in green and one in red—which shows that the actual major and minor construction funding has gone down, and that the funding needed reflected by the orange towers behind those green bar graphs. So this is a visual illustration of the problem.

(The provided material follows:)


Construction Funding Deficit Reaches $6.1 Billion
Cumulative Funding ($Billions)
0
1
2
3
4
5
6
7
8
9
FY 1997
FY 1998
FY 1999
FY 2000
FY 2001
FY 2002
FY 2003
Additional Funding to Reach 4% of Plant Replacement Value (PRV)
Actual Major and Minor Construction Funding

Annual VA Construction Funding Is Insufficient to Maintain Infrastructure



Mr. SIMMONS. We have quite a bit of ground to cover. I know my colleagues are busy. We had some delayed votes today. I understand eight colleagues were caught in an elevator in the Rayburn Building. They had a chance to get together and get to know each other very well. A little bit of bonding, but it did delay the day. So we will move forward.

And with that, I will recognize my colleague, the distinguished Congressman from Texas, Mr. Rodriguez.

[The prepared statement of Chairman Simmons appears on p. 52.]

OPENING STATEMENT OF HON. CIRO D. RODRIGUEZ

Mr. RODRIGUEZ. Thank you very much, Mr. Chairman. And I want to thank you for holding this particular meeting. I think it's important. And I know that in the area of construction projects, we all have in our back yards, as well as throughout the country, sites that are in great need.

It's not an overstatement to say that the VA's major medical construction program has been virtually dead in the last few years. We all know that regardless of what will happen with current or future planning activities, many of the VA facilities will be operating long into the future.

Tragically, many of the VA medical centers are well past their prime. The average facility, as indicated, was over 50 years old. And I don't have to tell you, that's a little bit prior to the microwave. So in terms of just electrical, you know, they're having some problems.

The health care delivery has changed drastically since many VA facilities were built, and the infrastructure no longer corresponds to the way services are provided. Worse, in far too many cases, facilities are unsafe to occupy.

We have a number of worthy projects that we are to consider today. One of the bills I'm co-sponsoring would fund a new health care delivery site in south Texas. And I have heard from many Texas veterans that have had to travel outrageous distances to obtain health care. And in some cases, it's close to 300 miles to go to San Antonio in order to get access to health care.

I know that in many other districts, there are many, you know, that also have to—you know, 4 hours, for example, from McAllen to San Antonio district, which is Congressman Ruben Hinojosa's area. There's a great need to expand that particular clinic there, and the services that are provided there.

In the Valley and the Coastal Bend area of Texas, the VA is meeting its access standard for acute hospital care for fewer than 3 percent enrollees. I want you to listen up on that. There's no other market in the entire country where we're so miserably failing our veterans, nowhere else than in south Texas, with those figures. Truly, something has to be done.

I know that the Evans bill has a number of important initiatives. The VA must keep the faith with the Chicago veterans and build a new west side bed tower there.

The Las Vegas area veterans desperately need a new ambulatory care center to replace its existing facility, which has been independently deemed unsafe for continued occupancy.

San Diego is one of the VA's highest risk seismic projects. And there's many more.

With all these, let me indicate that I was very pleased to see that Congressman Ortiz has also submitted a letter. Because the area that I was mentioning is serviced by both Congressman Ruben Hinojosa, Congressman Ortiz. And I have a portion of it, but the majority is under the other two congressmen. And, you know, there are a good number of—when you look at all the counties involved in those regions, the closest one is 150 miles to the nearest one, which is Nueces County, which is Corpus, which that county by itself has over 32,000 veterans. Hidalgo County has 25,000 veterans. Cameron County has close to 20,000 veterans. And there are some other surrounding counties around there. And so you see the number that are there.

So I want to thank you for holding this hearing, and hopefully, we'll be able to move forward and make something happen.

Thank you, Mr. Chairman.

Mr. SIMMONS. I thank the gentleman.

Our first panel consists of several representatives from veterans' service organizations, and I would ask them to come forward at this time.

Some may recall that at our last hearing, we heard from the VA and other witnesses. But time ran out, and our veterans service organization representatives very kindly agreed to submit testimony and avoid having us to come back after a 45-minute round of votes. And as a matter of courtesy to the VSOs for all the work they do, we decided to put them up front this morning. I hope Dr. Roswell and others will accept that explanation.

We have before us today, and we welcome, Cathleen Wiblemo, who's Deputy Director, Health Care, Veterans Affairs and Rehab Division, the American Legion. Welcome. Mr. Richard Jones, National Legislative Director of AMVETS. Mr. Adrian Atizado, Associate National Legislative Director, Disabled American Veterans. We have Mr. Carl Blake, Associate Legislative Director, Paralyzed Veterans of America. And we have Paul Hayden, Deputy Director, National Legislative Service of the Veterans of Foreign Wars.

Gentlemen, we have your statements—lady and gentlemen, we have your statements, and we suggest you summarize, give us some highlights. We will listen to all of you, and then have questions from our members. Please proceed.

Ms. Wiblemo.

STATEMENTS OF CATHLEEN C. WIBLEMO, DEPUTY DIRECTOR, HEALTH CARE, VETERANS AFFAIRS AND REHABILITATION DIVISION, THE AMERICAN LEGION; RICHARD JONES, NATIONAL LEGISLATIVE DIRECTOR, AMVETS; ADRIAN M. ATIZADO, ASSOCIATE NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; CARL BLAKE, ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA; AND PAUL A. HAYDEN, DEPUTY DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS

STATEMENT OF CATHLEEN C. WIBLEMO

Ms. WIBLEMO. It is a pleasure to be here today, and thank you, Mr. Chairman, for inviting the American Legion to present its views on these very important bills

For many years, VA's construction budget has virtually been ignored with regard to the funding needed to insure safety—in particular, seismic issues—modernization, and renovating of VA's enormous infrastructure. With the implementation of the Capital Asset Realignment for Enhanced Services, or CARES, initiative in fiscal year 2000, construction has nearly come to a standstill. Many needed construction projects have gone unfunded due to this stagnation.

For close to 3 years, VA has been assessing their infrastructure and health care need and demands into the years 2012 and 2022. Recently, the Veterans Integrated Services Network's market plans were submitted to the Under Secretary for Health. Through the CARES process, hundreds of construction projects have been identified. It is not clear yet how they will be prioritized. The projects represented in these bills are but a drop in the bucket when you consider the staggering scope and magnitude of the CARES initiative.

Although cognizant of the system-wide overhaul that may indeed result from the CARES initiative, the American Legion recognizes the specific facilities that require immediate attention, as well as the under-served areas in need of VA medical centers. The legislation being considered today is a welcomed relief.

With regard to H.R. 116, the Veterans New Fitzsimmons Health Care Facilities Act of 2003, the American Legion is pleased to support this legislation. The VA medical center in Denver is operating out of a 50-year-old building with lead paint issues, among other system shortfalls. This move would help facilitate sharing with the Department of Defense and continue the affiliation with the university, an affiliation that has proven to be very valuable to VA, and in turn, to the veterans in the local community. Ultimately, a new state-of-the-art building will positively impact the quality of veterans' care.

With respect to H.R. 1720, the Veterans Health Care Facilities Capital Improvement Act, this legislation offers immediate remedies for VA's critical construction needs, with a great deal of flexibility to allow the Secretary to target funding throughout the entire VA health care system. The American Legion is concerned that the local interests of the veterans' community may not be reflected in the decision-making process within the administration when targeting funds for specific facilities that may be in more need of im-

mediate attention than others. Every effort must be made to insure that the true needs of the stakeholders are taken into consideration before projects are approved.

H.R. 2349 authorizes certain major medical facility projects for the Department of Veterans Affairs, specifically at Chicago; San Diego; Clarke County, Nevada; and West Haven, Connecticut. The American Legion recognizes the fact that all of these facilities need immediate attention.

The American Legion National Commander, Ron Conley, has visited over 50 VA medical facilities this year. At each facility, he encounters firsthand the challenges faced by VA administrators, and the problems they must overcome in order to provide timely access to quality health care. These four facilities are no different. The American Legion applauds Ranking Democratic Member Lane Evans for introducing this important legislation.

I would like to add that Commander Conley's findings are being compiled in a final report on the current status of VA health care. With the cooperation of Chairman Smith, Commander Conley will be delivering this report to joint session in July.

H.R. 2307 provides for the establishment of new Department of Veterans Affairs medical facilities for veterans in the area of Columbus, OH, and in south Texas. Columbus, OH, is the largest city in the State of Ohio, and it is the largest city in the country without a VA medical center. Veterans in central Ohio have to travel an hour-and-a-half for surgeries, with Chillicothe being the closest VA medical center.

In south Texas, veterans face the same problem. The population is currently under-served and has been for several years. There is a great need there also to correct that problem.

Veterans in Columbus and south Texas will be better served through the enactment of H.R. 2307. The American Legion fully supports this bill.

Mr. Chairman, the legislation before us today is a solid step in the right direction to address the immediate construction needs of the VA's health care facilities. The American Legion commends you and the members of this distinguished subcommittee for the work that you have done and continue to do for the nation's veterans and their families.

That concludes my statement. I would be happy to answer any questions you or the subcommittee may have.

[The prepared statement of Ms. Wiblemo appears on p. 80.]

Mr. SIMMONS. I thank you for the statement. I think if the members accommodate me, we'd like to go through each of the five of you, and then ask our questions then. So Mr. Jones.

STATEMENT OF RICHARD JONES

Mr. JONES. Chairman Simmons, Ranking Member Rodriguez, members of the subcommittee, on behalf of National Commander W.G. "Bill" Kilgore and the nationwide membership of AMVETS, I thank you for this opportunity to present testimony on the bills before the panel.

AMVETS strongly supports the legislation subject to this hearing. With many VA centers in critical need of repair, improvements

to these facilities are essential to meet the health care needs of veterans.

For several years, VA's construction appropriation for major and minor projects has been in sharp decline. Coincident with declining levels of construction is the ongoing project of CARES, which continues to cause a great deal of foot-dragging on most of the construction projects authorized in the past by this subcommittee, and yet still needed by our veterans.

At least to the eye of most observers, the CARES project seems to be the impediment to proper care of veterans. The unfortunate situation we face forces VA to endure major unmet needs throughout the system. The condition of our VA facilities is not only an infrastructure problem, but a patient and staff problem as well. Our veterans have earned their health care benefits through their sacrifice and service.

When veterans use a VA facility, they should be assured that the facilities available to them not only have the equipment needed for their care, but are in safe condition for themselves and those who care for them.

AMVETS has been supportive of the CARES process. However, we believe the efforts of the CARES process must remain separate from the urgent needs of the VA infrastructure and facilities. CARES is for tomorrow. But these facilities and the staff and patients they house need help today. Clearly, more resources are needed to be devoted to our medical care, and construction should not lag behind the need for medical care.

With these concerns in mind, AMVETS is encouraged to see that H.R. 1720 would authorize appropriations of $500 million for major VA construction for the next fiscal year, and further increase that level by an additional hundred million over the next 2 fiscal years.

AMVETS would also recommend increasing the limit for individual minor construction projects from the current level of $4 million to $10 million. By increasing this cap, we would enable VA to better address facility improvements.

Mr. Chairman, AMVETS applauds the subcommittee's efforts to authorize the needed resources to allow VA to maintain and modernize the over 2,000 buildings in its health care portfolio.

Thank you again for the opportunity to present our testimony. We sincerely appreciate your vigilance and your care for the nation's veterans. Thank you.

[The prepared statement of Mr. Jones appears on p. 87.]

Mr. SIMMONS. I thank you for your comments, Mr. Jones. Mr. Atizado.

STATEMENT OF ADRIAN M. ATIZADO

Mr. ATIZADO. Good afternoon, Mr. Chairman, members of the subcommittee. I am pleased to express DAV's views on the four pieces of legislation which address infrastructure needs of the Department of Veterans Affairs. These bills recognize that for more than a decade, the VA has not been provided with adequate appropriated funds for its major and minor construction projects. Although DAV has no resolutions concerning these bills, we have addressed these issues in the independent budget. Therefore, we do

not have objections to the favorable consideration of these bills by the subcommittee.

H.R. 1720, the Veterans Health Care Facilities Capital Improvement Act, strikes directly at the matter before us. Many VA facilities need funds right now on an emergency basis for major and repair projects as well. Other facilities have more chronic needs for restoration and capital improvements that have lingered unfunded for years.

While this bill authorizes $1.8 billion over 3 years, the Independent Budget recommends for fiscal year 2004 alone that Congress appropriate $926 million for major and minor construction. That is just over half for fiscal year 2004 alone.

H.R. 2349 provides for seismic corrections of Building 1 of the San Diego VA medical center. Now, this building is classified as exceptionally high risk, and such constructions would mitigate life safety hazards and allow for continued operation, even after a seismic event. The bill would also provide for new construction projects for a multi-specialty outpatient clinic in Las Vegas, Nevada, and a bed tower to be consolidated with the West Side VA medical center in Chicago, Illinois. Such projects would accommodate the loss of a VA medical facility in both areas and preserve the full continuum of high-quality VA medical care.

H.R. 116 would allow the Secretary of Veterans Affairs to carry out major medical facility projects at the former Fitzsimmons Army Medical Center in Aurora, Colorado.

Now, DAV recognizes the need for a modern health care facility in the Denver area, and the value and importance of maintaining relationships with medical affiliates. However, we have serious concerns about an integrated inpatient facility with joint governance and management.

So whatever options are approved for the Denver area, we believe VA should maintain a strong presence in this by keeping a separate identity with direct line authority in all areas involving care of veteran patients. This will allow VA to fulfill its primary health care mission to serve the needs of America's veterans by providing primary care, specialized care, and related medical and social support services.

H.R. 2307 would provide for medical construction projects in south Texas and on available federal land at the Defense Supply Center in Columbus, OH. We do note that the CARES process has recognized substantial needs for these facilities at these particular areas.

The DAV, along with Independent Budget veterans service organizations, supports the CARES process. However, CARES has an continues to be a major contributing factor to VA's diminutive annual budget for major medical construction projects.

Deferrals of funds for needed construction projects were intended to permit CARES to proceed in an orderly way, avoiding unnecessary spending on health care facilities that might not be needed by veterans in the future, yet these deferrals negate the interim infrastructure needs. It has resulted in adverse effects on health care quality and capacity, as well as the loss of capital assets value.

If construction funding continues to be inadequate, it will become increasingly difficult for VA to provide high-quality services, espe-

cially in old, inefficient, and unsafe patient-care settings. Clearly, more must be done through the regular appropriations process in the annual budget for VA construction.

Mr. Chairman, we look forward to working with the members of this subcommittee and the full committee to obtain funding necessary to restore and maintain a viable modern world class health care system.

This concludes my statement, Mr. Chairman. Thank you. And I'd be happy to answer any questions you may have.

[The prepared statement of Mr. Atizado appears on p. 92.]

Mr. SIMMONS. I thank you for that statement. Mr. Blake.

STATEMENT OF CARL BLAKE

Mr. BLAKE. Chairman Simmons, Ranking Member Rodriguez, members of the subcommittee, PVA would like to thank you for the opportunity to testify today on the proposed construction legislation.

PVA strongly supports H.R. 1720, the Veterans Health Care Facilities Capital Improvement Act, introduced by you, the Chairman. PVA has been a leading advocate for similar measures in the past, because the Department of Veterans Affairs is indeed facing a crisis.

Last Congress, PVA enthusiastically supported a similar measure, and many of our concerns remain the same. We previously testified that according to a Price Waterhouse study conducted in 1998, the VA should be spending between 700 million and $1.4 billion annually, as well as similar amount for non-recurring maintenance.

This year, the Independent Budget called for major construction appropriation of $436 million, as well as 400 million for CARES advanced planning and design initiatives. We are pleased that H.R. 1720 authorizes $500 million in FY 2004 for the major construction projects identified in Section 2 of this legislation.

PVA also applauds the subcommittee for its explicit recognition of the importance of spinal cord injury centers and specialized service programs within the scope of the Veterans Health Care Facilities Capital Improvement Act. We are pleased to see that improved accommodation for persons with disabilities, including barrier-free access, is a goal of this bill.

PVA wants to state unequivocally that these much-needed construction funds must not come at the expense of or out of the medical care budget line item that provides direct health care service to our veterans.

The VA medical system is facing a crisis brought about by inadequate funding, a crisis that has led to health care rationing and shocking waiting times faced by all veterans across this nation. The solution to this crisis lies in providing the funding required by VA health care in the medical care account. The crisis facing VA infrastructure, likewise, will be solved by providing the necessary additional resources in the construction line item.

PVA has concerns regarding H.R. 116, the Veterans' New Fitzsimmons Health Care Facilities Act of 2003. PVA stands committed to finding workable solutions for the delivery of veterans health

care in the Denver area, and we've worked tirelessly toward this end.

PVA understands that constructing a new, freestanding VA medical center at the Fitzsimmons site is no longer feasible due to space limitations at the site and cost concerns. We are adamantly opposed to any option that would essentially integrate Denver VA medical patients into the patient population of the University of Colorado Hospital. We are open to the many collaborative opportunities between the two entities, but integrating veteran patients in this manner would fundamentally change the way VA provides care.

We believe that an option involving the VA leasing within a new facility could be a viable one, as long as many essential elements are included within such a plan. We also believe that a new spinal cord injury center is needed in the Denver area, and that this center should move forward, along with any decisions concerning Fitzsimmons.

Any new SCI center must be operated, as all current centers are, with dedicated services and staff. The development of a new SCI center must follow the requirements of the Memorandum of Understanding between VA and PVA allowing for architectural review, must operate in compliance with all existing VA policies and procedures, and must continue the relationship between VA and PVA, allowing for site visits of SCI center facilities.

PVA stands ready to work with the subcommittee to insure that veterans in Colorado are accorded the very best VA health care.

PVA supports H.R. 2349. One of our gravest concerns over the CARES process was that this initiative would be used as an excuse to shutter VA facilities, rather than to enhance the health care provided to veterans and move the VA health care system into the 21st century. We have increasing concerns as the CARES process unfolds that it will be easier for CARES planners to close facilities than it will be for them to actually produce the resources to make needed enhancement at other facilities at the same time. For this reason, we applaud the provision in H.R. 2349 which prohibits the disposal of the Lakeside Division medical facility in Chicago, Illinois, before the VA has entered into a contract to construct a new bed tower at the West Side medical center.

Likewise, we support construction or facility authorization measures, such as H.R. 2307, if these measures address demonstrated needs. We have consistently stressed that necessary construction must proceed regardless of the CARES process. Veterans still seek health care, and these services must be provided.

Likewise, the Independent Budget has stressed the importance of preserving VA's historic structures, and the fact that the CARES process is ill-equipped to address this vital concern. The Independent Budget calls for the development of a comprehensive national program on historic properties and the provision of adequate funding for this important preservation work.

In closing, the final outcome and the effective results of the CARES process remains to be seen. But this is no excuse to not provide vital construction and maintenance dollars, nor should it serve as an excuse to close hospitals without providing the enhanced services that are a key component of the CARES acronym.

I'd like to thank you for the opportunity to testify today, Mr. Chairman, and I'd be happy to answer any questions you might have.

[The prepared statement of Mr. Blake appears on p. 97.]

Mr. SIMMONS. Well, thank you for that testimony. Mr. Hayden.

STATEMENT OF PAUL A. HAYDEN

Mr. HAYDEN. Mr. Chairman, members of the subcommittee, on behalf of the 2.6 million men and women of the Veterans of Foreign Wars of the United States and our Ladies Auxiliary, I would like to extend our appreciation for being included in today's important hearing on these bills related to VA construction projects.

While we, as well as this subcommittee, appropriately focus the majority of our attention on medical care, it is essential that we place an emphasis on VA's decaying physical assets.

VA has one of the largest building inventories in the Federal Government, nearly 5,000 buildings. Not only does the sheer size of the system create difficulties, age does too. Although many new facilities have been built in recent years, the average age of VA buildings is over 50 years old, and growing older each day. Despite recent increases, the amount of money appropriated for major construction is significantly lower than it was even 10 years ago, as the committee's charts clearly show.

It's essential for VA to build, renovate, and maintain health care facilities that are able to provide quality health care without sacrificing patient and worker safety and convenience, so VA can continue to take care of our nation's veterans long into the future.

Therefore, the VFW is pleased to strongly support H.R. 1720, the Veterans Health Care Facilities Capital Improvement Act. We feel this legislation would be a great benefit to veterans, as it would significantly enhance VA's ability to carry out major construction projects.

First, it would improve VA's ability to respond to its immediate needs by authorizing major construction projects. Second, it would provide VA with greater flexibility in choosing projects, resulting in timely repair of urgent priorities. Finally, and most importantly, it would authorize $500 million in appropriations for fiscal year 2004 for major construction.

Turning to H.R. 116, we are generally supportive of this legislation, as it would result in a new medical facility for Denver-area veterans. However, we do have some reservations. First, would veterans remain a priority? VA must have proper representation on the governing board of the complex, which would be constructed in cooperation with the University of Colorado. Without proper representation, we cannot be assured that veterans would receive the priority access and care they are entitled to.

Second, how responsive could VA be to veterans' needs, given a less-than-complete share of authority on that governing board? VA must be able to adapt to any changes in the veteran population, in technology, in health care, and business practices to remain able to effectively treat veterans. Without proper control and representation, the partnership may compromise this ability.

If we can receive assurances in the answers to these questions, we will be pleased to support the legislation more strongly. We

must be convinced, however, that the partnership will not erode VA's ability to provide timely, accessible, high-quality care to Denver veterans.

Finally, the VFW supports both H.R. 2349 and H.R. 2307. These bills authorize major construction projects at sites around the country to construct and repair inpatient and outpatient facilities, as well as to improve safety.

In closing, we continue to believe that VA should not delay major construction projects if there is already a demonstrated need, yet that is exactly what the CARES process is preventing. While supportive of the CARES concept, the process has taken 3 years already. And just this past week in a memorandum dated June 4, VA Under Secretary for Health, Dr. Robert Roswell, stated that the process will be delayed again as they aim to gather more information.

As we and other veterans organizations stated in the Independent Budget, while VA planning has ignored its current construction responsibilities and focused exclusively on the CARES promise of guidance, the perfect has become the enemy of the good.

Mr. Chairman, this concludes my testimony. I would be pleased to answer any questions that you or members of the subcommittee may have.

[The prepared statement of Mr. Hayden appears on p. 103.]

Mr. SIMMONS. Thank you very much. Thank you all for your testimony. I have a couple of questions, and then we will go back and forth, as is our custom.

For Mr. Jones, on page 3 of your testimony, you make reference to the Independent Budget and a recommendation to move the authority of the Secretary to approve minor construction projects from 4 million to 10 million. As I recall, in the last cycle, we played with that number and got it as high as 8 million, but never got anything out of the pipeline.

Do you recommend, for example, that in one of the bills before you, or even in a separate bill, that we include that threshold to give the Secretary that flexibility? Is that the recommendation of your organization?

Mr. JONES. That is our recommendation, Mr. Chairman. What you attempted last year is still appropriate. The conditions remain the same. We do think, however, that $10 million might be a better level. Many of the facilities could stand some real improvements in these areas, and they simply can't move forward under the current cap.

Mr. SIMMONS. And so that might be considered as a markup item, let's say, for H.R. 1720.

Mr. JONES. Yes, sir. That would be an excellent place for it.

Mr. SIMMONS. Does anyone else have a comment they would like to make on that subject?

[No response.]

Mr. SIMMONS. Hearing none, I have a second question with regard to the American Legion, Ms. Wiblemo. You expressed concern that with regard to H.R. 1720, the local interests of veterans' community might be ignored in the process. Obviously, what that legislation is designed to do is give the Secretary substantial authority to break the log jam, if you will, on some of these projects. And it's

been crafted with an independent review by a board to either endorse or perhaps advise the Secretary.

It seems to me that that provides some counterbalance there. But how would you recommend we incorporate the local inputs to that type of a system?

Ms. WIBLEMO. As I stated in the testimony, the concern is that the veterans' opinion or their needs will be overlooked for other reasons. The counterbalance of the board and the independent review is a good one. I mean, we definitely support that.

We are just concerned that veterans aren't always heard, and we would be suspect of any process that would have a tendency to overlook that. I don't have any specific recommendations right now. I'd have to go back and look through that.

Mr. SIMMONS. Thank you very much. One final question. I believe in the past, the PVA has testified with regard to their concern for historical preservation. And obviously, there's good news and bad news in the veterans system. The good news is that we have some wonderful historic buildings out there. The bad news is that we have some wonderful historic buildings out there. And the challenge for us is how do we preserve and protect that history, but also provide our veterans with state-of-the-art health care.

Expanding on that a little bit, hospice care, long-term care, certain types of residential environments are activities that the VA might logically be involved in. And maybe some of these older buildings would convert to that purpose, and scarce dollars could then be applied to newer facilities for top-of-the-line medical.

Would you like to—Mr. Blake in particular, would you like to develop that concept? Is that something that your organization has a specific interest in?

Mr. BLAKE. Mr. Chairman, we'd be happy to work with the subcommittee and the VA on that. Historic preservation has always remained a priority to us, along with, obviously, the spinal cord injury centers. And we recognize the fact that the VA infrastructure is aging rapidly. I believe last year in the Independent Budget, VA buildings had an average age of like 73 years, or somewhere in that range. And so just about every VA building, it seems, would qualify for historic preservation at this point, based on that number.

But we don't want to sacrifice those buildings at the cost of new construction. And I know yesterday, there was some discussion in the hearing about the cost to renovate many of these older buildings versus new construction would be greater, but we still don't see it as—the means should not be to—or we should not eliminate these historic buildings for that end goal. If there is a use out of these buildings, we would like to explore it as much as possible.

Mr. SIMMONS. I thank you for that comment. My father happened to be an architect for 65 years of his life, and he always said it's more expensive to renovate an existing building than to build a new one. But if the renovated purpose is somewhat different, not top-of-the-line, lower tech, and his specialty was building hospitals, then you could preserve the historic building into an alternative use, and again apply your dollars to building new facilities to provide high-line or top-of-the-line medical care.

So I thank you for that comment.

Mr. Rodriguez.

Mr. RODRIGUEZ. Thank you, Mr. Chairman. I want to thank you all for being here.

Let me—I guess a question to all of you, and then one to Mr. Blake. Because I know you mentioned that Price Waterhouse report. And what was the percentage of infrastructure that you felt that you came up with a 700 million figure?

Mr. BLAKE. The number from the study said that the dollars spent that the VA should be spending annually on construction projects should range from I believe it was 700 million to $1.4 billion dollars. I don't actually have the study, but I can certainly go back to the office and get all the information we have on that study, and I'd be happy to provide it to your office.

Mr. RODRIGUEZ. And what percentage was that? Because I noticed the one we have up there is 4 percent for just the maintenance cost up there on this handout.

Mr. BLAKE. That follows with what the charts were showing here.

Mr. RODRIGUEZ. Okay. The same?

Mr. BLAKE. Yes.

Mr. RODRIGUEZ. Okay. And the other comment was my understanding was that most of the VA organizations were supportive of CARES initially, and now with what's happening, I guess what happened in Chicago and the fact that—I'm wondering, you know, how you might feel about that now and the need to move forward, you know. And I'll just get anybody's reaction to that.

Mr. JONES. AMVETS continues its support of CARES. We think it's an appropriate process. It needs to be done. We need to look to the future. We do, however, find it very difficult to put some of the pieces of this puzzle together. As we look to the future and at some of the facilities that do not fit into that vision, we're concerned about how we pay for the construction of those facilities that the CARES process finds are needed.

It's an age-old problem trying to get the Appropriations Committee to lever out some dollars for construction. It's always easier to reduce funding for a facility that's no longer needed, found to be obsolete. But we still have that problem at the other end of CARES. As Carl explained from PVA, it's the E factor, isn't it, Carl?

Mr. BLAKE. That's correct.

Mr. RODRIGUEZ. Anyone else on that?

Mr. BLAKE. I would say from PVA's perspective, we've always been supportive of CARES. It's underlying concept, you can't help but support.

The problem we've had with the CARES process is that there's basically been a moratorium on all construction projects as a result of CARES. Everything has been—for the last few years, it's been a discussion of "Well, let's wait and see what the CARES process says or they come up with before we decide what to do in the realm of construction." And in the meantime, we end up in a situation where we were talking about where we end up with buildings that are reaching a historic age because no construction is being done to renovate them.

And the other problem we've had with the CARES process—like I said, we continue to support it—we also had a problem with the fact that long-term care was not given enough—or was not looked at in the CARES planning, I should say.

Mr. RODRIGUEZ. How do you think we ought to handle—because I know I have a problem in south Texas in terms of not having access, period. We don't have the old facilities. We never had them. So how do you—and I had that problem also with nursing home care, because this same committee here decided to fund—go with the recommendation of the existing groups to build construction of the old facilities when we were trying to get new ones. So how do you strike a balance there?

Mr. ATIZADO. Well, sir, the need in south Texas, I'm sure you're well aware veterans take about a 5- or 6-hour drive in DAV vans out of south Texas to seek medical care. The CARES process did identify that need. But as it's been mentioned here, the CARES process has identified many areas that have many needs.

And as I testified earlier, it's not so much that we don't believe the CARES process, that it will come out with enhanced services part, but that bills such as these that is on the agenda today will cause construction to come out of line.

And the CARES process is a nationwide process. I understand that it's a whole plan. And what these bills does is take specific construction needs in the CARES process and implements that if they're enacted. And our concern is whether this would be mindful to the process in and of itself, since the goal is enhanced services.

Mr. HAYDEN. The VFW, I'd just like to say, supports the concept of CARES. We do. And I agree with that concept. But we'd like to see it on a separate line item, though, from construction budgets. We would like to see the construction funds authorized and appropriated so we can go ahead with the projects that need to be done now, rather than waiting for the CARES process to be completed. So we'd like to see those almost funded on separate line items.

Mr. RODRIGUEZ. Iraq had 2 billion for health care for Iraqis.

Mr. SIMMONS. Mr. Beauprez.

Mr. BEAUPREZ. Thank you, Mr. Chairman. Thanks for holding this hearing today. I think you're fully aware that especially H.R. 116 is close to my heart. I represent Colorado, so I'll focus most of my comments on it.

I'll also disclose that I've got another hearing going on in another committee that is also close to my heart. So if I have to leave you suddenly, it is not for lack of interest. Dr. Roswell, my apologies.

And Mr. Chairman, if I might, I'll submit an opening statement for the record.

Mr. SIMMONS. Without objection, so ordered.

Mr. BEAUPREZ. Thank you.

[The prepared statement of Congressman Beauprez appears on p. 60.]

Mr. BEAUPREZ. Relative to historic preservation, the Fitzsimmons campus actually holds a rather unique opportunity. The old 500 Building, as it is called, the old Army hospital itself, is where President/General Eisenhower recovered from a heart attack back when. And it's nice that that building is not only being maintained, but being restored. And the actual room he stayed in is being re-

stored to its original state, complete with furniture and appliances and incidentals that were there when Ike recovered, which is kind of fun.

I want to again focus on Fitzsimmons. And gentlemen, especially Mr. Atizado—did I pronounce it correctly——

Mr. ATIZADO. Yes.

Mr. BEAUPREZ (continuing). Mr. Blake and Mr. Hayden, your concerns are very much noted, and have been noted. And if I might summarize, your concerns are, one, independence, especially in the facility itself, physical independence, and especially governance, that the needs and the wants, the desires of veterans are not only initially heard, but that the veterans don't become the tail on the dog, if we can put it in that context.

I had heard that from my veterans back home. I had heard that from our various VSOs. I had heard it from the UVC in Colorado. And frankly, the very first time I raised this issue with Secretary Principi, he was the first one that brought it up. I didn't have to bring it up. So I can tell you that it is the Secretary's concern as well.

And let me also share with you, because I'd like to get your reaction to this. We have met numerous times on site with representatives of the University of Colorado Hospital, with the veterans organizations, with the VISN director, with representatives of the VA, again, as well as DOD. One, there is a possibility, if we can find the ability to act relatively quickly and secure the pad site, to, in fact, construct a separate VA tower. That site planning has been done and enthusiastically supported by all the parties. So that independence, I think, is secured—again, if we can act relatively quickly—which excites a lot of us.

From a governance standpoint, if I can put it in that context, I think everybody is in agreement that that can be handled contractually with the various parties so that you know who's at the table, and how decisions get made, and how representation is dealt with.

Mr. Blake, I believe you raised the question about a spinal cord injury center. I think that from our veterans, that is a huge priority. From my own personal standpoint, it is a huge priority. From the standpoint of the University of Colorado Health Sciences Center, it is obviously a huge priority, because it enhances their reasons for being.

The synergy of this site, I think, holds tremendous opportunity, if those things can be realized. Here is my question. Independence, governance assured, and especially —and I think this is the most important part—expanded capability for good, quality medical care for our veterans, not only now, but for the future. If we can secure that, have we satisfied, essentially, your critical reservations about 116? Mr. Hayden?

Mr. HAYDEN. From the VFW's standpoint, yes, sir. I mean, if we can get those assurances. You know, as long as VA is able to provide timely, you know, quality care to veterans, and veterans don't become second-class citizens, you will definitely have resolved a lot of our issues with this, and we will strongly support that.

Mr. BEAUPREZ. Thank you. Mr. Blake?

Mr. BLAKE. Mr. Beauprez, I would say that you have addressed many of the issues that we've had. In my written statement, I men-

tioned that we had grave concerns with the governance. We would also like to see that the staff members who are providing the medical care remain federal medical center employees. There's also some concerns with insuring that the VA continues to use its current policies and procedures with regards to pharmaceutical supplies and prosthetics, and that arena.

But as laid out like you say it, it's hard to not support your plan. But we would like to see that certainly, that's the way to go.

Mr. BEAUPREZ. You bet. Understood. Mr. Atizado.

Mr. ATIZADO. Well, sir, as I mentioned earlier in the testimony, we don't have a resolution to support the bill. But seen as what you have mentioned does address directly our concerns, we would have no objection to the legislation.

Generally, in local issues such as this, we do defer to our department level, Disabled American Veterans—I'm sorry—state level organization, and the local veterans in the area as well, to see—and insure that they do have input in that. And if they believe that it is—that their concerns are going to be met, then we would leave it up to them, sir.

Mr. BEAUPREZ. And not to leave you out, but Ms. Wiblemo and Mr. Jones, if I understood correctly, you're pretty enthusiastic about this.

Ms. WIBLEMO. Yes. We fully support this bill.

Mr. JONES. It's amazing that Eisenhower's heart didn't give out earlier, understanding how he had to deal with Montgomery.

Mr. BEAUPREZ. I'll take that as a yes.

Mr. JONES. But he was the right man at the right time. He was the right man for that European theater.

Mr. BEAUPREZ. Well, Mr. Chairman, just for the record, I would be remiss if I didn't point out that I think there is a relatively narrow window of opportunity out here. Because this is one of the last remaining pads on the Fitzsimmons campus. I think it's an aggressive and a great opportunity. And hearing the concerns of the veterans organizations, I think, is very important.

And I would say also for the record that there is no single issue among my VSOs in Colorado and the UVC that so enthusiastically is supported as is this hopeful move to Fitzsimmons. And so noted the concerns of these witnesses today. They've been addressed on site and in repeated meetings. I think that they're very justifiable. And I'm committed as a member of this committee to doing what I can to make sure that those concerns are addressed, and hopefully, we can move this great project forward.

Thank you, Mr. Chairman.

Mr. SIMMONS. I thank the gentleman, and I recognize Mr. Snyder.

OPENING STATEMENT OF HON. VIC SNYDER

Dr. SNYDER. Thank you, Mr. Chairman. I just have a couple of questions. Mr. Hayden, in your statement—and you've repeated here, I think discussed it, but you state, "We feel the CARES process is being used as an excuse to not do any major construction, all while the aged VA infrastructure deteriorates daily." And you go on to say, "While we appreciate and support the idea of CARES,

we strongly believe that this cannot preclude the VA from construction, especially high-risk buildings."

It reminds me a little bit about the base closure process in the military, which is we have a process that's been talked about for years. But in no way has—there are two different tracks. Track 1 is there's a lot of construction going on at bases, because we feel that the military has needs now. And while we do have another—if we have another round of base closure, and I think we will, we clearly will close some bases that have some nice, relatively new buildings on it.

But the trade-off is you don't treat your personnel correctly, because years can go by while you're talking about this process. I don't know if that's a correct comparison or not.

The specific question I wanted to ask is with regard to research space and research facilities, several of you represent—probably all of you represent organizations that feel very strongly about the role of research at veterans facilities because of some of the special needs, whether it's hepatitis C or neurological injury or spinal cord injury, all those kinds of things.

In H.R. 1720, one of the priorities there is it specifically mentions that research. It says, "Improving, replacing, or renovating a research facility, or updating such facility to contemporary standards." I may have missed it, but I don't think any of you in your written statement make any reference to research. Are we all in agreement that that is something that you all think should be part of the priority of the construction?

Mr. HAYDEN. I definitely agree that research should be part of that. I think it's one of the key things that VA does, and it does well. And if that infrastructure is not upgraded along with the existing infrastructure, then, you know, it can be a detriment to our nation's veterans.

Ms. WIBLEMO. Yes. The American Legion feels the same way as far as research is concerned. We're big supporters of it, and we would like to see a lot of the renovation take place so they can continue that work.

Dr. SNYDER. I appreciate your statements. It's, I guess, part of just the way the market works. To really get really good researchers, there's a market out there for them. If they don't have good facilities, they're going to go with some place that does have good facilities, and that means working somewhere else.

Thank you, Mr. Chairman. Thank you for your comments.

Mr. SIMMONS. I thank the gentleman. And if the gentleman refers to page 3, line 16, of H.R. 1720, he will find reference to research facilities.

Dr. SNYDER. No. I specifically read from page—my page 3 is line 1, paragraph 6. Do we have different drafts of the bill?

Mr. SIMMONS. That's a possibility.

Dr. SNYDER. Oh, yeah, down here. I see.

Mr. SIMMONS. All I'm saying is that the language is very good language. It came from a very good source, and it includes research facilities.

Dr. SNYDER. No. That's the language I read from.

Mr. SIMMONS. You'll find it familiar.

Dr. SNYDER. Yeah, that's right. Thank you.

Mr. SIMMONS. The Chair recognizes Mr. Boozman.

Mr. BOOZMAN. I don't have any questions.

Mr. SIMMONS. The Chair recognizes Mr. Strickland.

Mr. STRICKLAND. Thank you, Mr. Chairman, and thank you those of you who have provided testimony today.

I was struck by the fact that you all support the CARES approach or philosophy. But you have legitimate concerns about what the final outcome may be, and whether or not the research that comes out of that process may be used in an appropriate way that will benefit the health care provided to veterans, rather than as an excuse to perhaps close facilities in a way that could be detrimental to the service the veterans receive.

Is that an adequate summary of how you feel about the process, or am I trying to put words in your mouth?

Mr. JONES. I think you express it well, sir. We don't wish to see resources go inappropriately to obsolete facilities. So when those resources could be better used for health care of veterans or for improving the facilities in which veterans are cared for.

Mr. STRICKLAND. Anyone else care to response to that?

Mr. BLAKE. I don't think it can be said any better than Mr. Jones just said it.

Ms. WIBLEMO. I would just like to say for the American Legion that one of the biggest concerns we have—we do support the CARES process. We have from the beginning. And we have had concerns. A lot of them have been expressed here today. But one of the bigger concerns that we had from the beginning has been the compressed time schedule of the actual process, especially the Phase 2 portion of it, and then into the strategic planning, and the next iteration, if you will.

But we have been very concerned over that compressed time schedule. So other than that, we definitely support CARES.

Mr. STRICKLAND. Okay. And coming from Ohio, I guess I have a special interest in H.R. 2307, which would result in a facility being constructed in Columbus, OH, which I understand from some of my colleagues is the largest metropolitan area perhaps in the entire United States of America that does not have a major VA hospital.

But I'm wondering, in your testimony today, are you prepared to endorse each of these bills in terms of what they're trying to accomplish, or are you just simply saying that you support in concept the need to provide adequate facilities?

I guess what I'm asking for—and something, you know, that I question myself—when the bill to construct the Columbus Hospital was introduced—obviously, I'm naturally supportive of that for rather parochial reasons, perhaps. But is it your opinion that—and I think you've answered this—that although you support the CARES process, you recognize that there is a need that exists now that should be addressed quickly, and that may mean the expenditure of significant sums of money before we get whatever the final recommendations are that may come from CARES? And that these bills that we have before us today that we're looking at, if they meet a legitimate need, you would be very supportive of supporting to completion.

Mr. JONES. Yes, sir. Take, for example, the Ohio situation. Is there a facility in Ohio that is obsolete? Is there no need in Ohio? Clearly, there's a need, and clearly, funds should be spent there.

The only surprise continually in these construction authorizations, that the lists are so small. In taking a look at the charts, it is clear that there have been construction projects that have fallen by the wayside and in the cracks over the years.

There must be intense competition. And we're pleased to see the facility in Ohio, we're pleased to see the facility in south Texas, and other facilities where these hospital needs are so important. And we'd like to see one in Nevada as well.

Mr. STRICKLAND. I spent several hours in Cleveland, OH, which is not in my immediate district, but, you know, serves people who are living in my district at the VA resources center there at the Federal Building. And then I went to the hospital there in Cleveland and spent a couple of hours. And I know in addition to the Columbus facility, there's great interest in doing something with the old Brecksville facility, and either replacing it on site in Brecksville, or even perhaps the possibility of moving that operation to the Cleveland hospital site and building a new facility there.

The needs are obviously out there. And I'm just happy to hear you say that you support the CARES process, but you don't want to wait for it to be completed before we address these very critical needs that currently exist and should be addressed now.

So I want to thank all of you for very helpful testimony today. Thank you.

Mr. SIMMONS. I thank the gentleman. Before recognizing Ms. Brown-Waite, I will notify members that I hear there's going to be a vote around 3:30. And we have Mr. Roswell waiting patiently. So I just let members know, and I now recognize Ms. Brown-Waite.

Ms. BROWN-WAITE. In light of the hour and the 3:30 vote, I'll pass at this time, Mr. Chairman.

Mr. SIMMONS. I thank the lady. And I now recognize Ms. Berkley.

Ms. BERKLEY. Thank you.

Mr. SIMMONS. I'll bet she has something to say.

Ms. BERKLEY. I have a few things. (Laughter.)

And thank you for recognizing me. Thank you, Mr. Chairman, for holding this very important hearing today.

A multi-specialty outpatient clinic in Las Vegas is essential to meet the current and future needs of the veterans in my district. And I particularly want to thank Ranking Member Evans, the Department of Veterans' Affairs, particularly Under Secretary Roswell, and this committee for making the new clinic a high priority.

I appreciate the fact that you're all here. I work very closely with all of your members in Las Vegas across the board with all of my VA organizations. And I can tell you that they are a strong and rabid group that I deal with on a daily basis, and I appreciate the fact that you are representing them here.

I also appreciate the testimony of the American Legion for pointing out on page 4 the problems with the Las Vegas VA clinic that's currently in the process of being closed. I sometimes think that my

colleagues think I'm exaggerating. But when you read about the unsafe air pressure in the surgery room, which has never been used, inadequate floor supports, and filling the drains of the sink with disinfectant because sewer gases keep bubbling up and making the employees of the VA clinic sick, believe me when I tell you I am not exaggerating the problems that we have.

As you are all aware, Clarke County has one of the fastest-growing veterans populations in the United States. The VA has projected that the number of enrolled veterans needing health care services in Las Vegas will increase by 18 percent over the next decade, a time when the rest of the nation's veterans population is declining.

The southern Nevada veterans health community is struggling, struggling to meet the needs of the population growth, and this has been compounded by the evacuation of the Adelaire Del Guy Ambulatory Care Clinic that is currently under way.

Concerned about the current situation in Las Vegas, this committee sent a bipartisan team to visit the former clinic and several interim health care facilities throughout Las Vegas. The staff members were astounded at the decrepit condition of the former clinic, which I remind you is only 5 years old, and agreed that southern Nevada's veterans deserve far better. As a matter of fact, I believe one of the staff members was overheard saying, "Let's get out of here before it falls down on our heads." You could imagine what my veterans feel, having to get health care there on a daily basis.

For the next 3 years, veterans in my district will shuttle between 10 different temporary locations to have their health care needs met until one full-service clinic can be constructed. In the past 3 weeks, the VA has opened two of those temporary clinics. The VA is now in the process of opening the remaining eight clinics.

While I'm pleased that the transition has moved forward fairly smoothly, I'm very concerned about the future challenges and inconveniences. I don't want anybody to think for a minute, and I'm sure you're hearing from your members, that the veterans are happy with the 10 temporary interim site solution. I can assure you that my veterans were up in arms at this solution, and the only way we were able to assuage their concerns and get them to calm down and accept an interim solution of 10 locations is the promise from the VA, the promise from me, the promise of other people in positions of authority, that they will, in fact, have a new clinic within 3 years.

Veterans with multiple or specialized health care needs will still need to be shuttled between locations. Let me give you a for-instance, because any one of your members can be subjected to this. A veteran who needs a CAT scan may have to shuttle from their primary care location to another temporary site which houses the CAT scan technology, and then to another site for a prescription for the controlled narcotic, and still another site for the mental health services. Also, female veterans who need a mammogram or other gynecological services will have to shuttle to yet a different clinic.

While veterans have shown tremendous resilience thus far adjusting to the temporary sites, let us not forget that the population we are talking about are rapidly aging people. Shuttling between locations for various services in 110-degree Nevada heat is a con-

siderable burden for anyone, particularly for our oldest and sickest veterans. Maintaining 10 separate locations is not an acceptable permanent solution.

Southern Nevada's veterans are facing a health care crisis, and I don't think anything less than a crisis is the appropriate word. They have a fragmented clinic, no long-term care, no nursing home facility, and are forced to travel to veterans hospitals in California for essential hospital services. We need a health care clinic, and we need it now.

Under Secretary Roswell, I am committed to pursuing every avenue to make sure the veterans in my community get this clinic that they so justly deserve and need. I hope that as the process moves forward, the VA will keep me informed of all major developments, that we'll all be able to work together. Our top priority should be meeting the needs of our veterans throughout the United States, particularly in areas like Las Vegas, with high-growth veterans populations. And I hope we're all going to work closely together in the coming months.

And if I may, in addition to thanking all of you for being here, when Mr. Roswell comes to testify, I would be very grateful if he would answer a question. Because I want to make sure that the VA is moving forward with its commitment to providing one multi-specialty clinic to meet the needs of veterans in Las Vegas, rather than having 10 temporary locations becoming the permanent solution. I am extremely worried about this possibility, and I'd appreciate if Dr. Roswell would comment on this when he has an opportunity to testify.

And I thank you all for taking your very valuable time to come and enlighten us and share your concerns with the committee.

Mr. SIMMONS. I thank the lady for her question.

Ms. BERKLEY. Was that okay?

(Laughter.)

Ms. BERKLEY. Was my question—do you agree?

Mr. SIMMONS. Right. They're all nodding, let the record show. I want to thank the panel for their testimony. And at this point, I would invite the second panel to come forward. We have the Honorable Robert H. Roswell, Under Secretary for Health, Department of Veterans' Affairs. And he's accompanied by Mr. Mark Catlett, who is Principal Deputy Assistant Secretary for Management; and Mr. Robert Neary, who's the Associate Chief Facilities Management Officer for Service Delivery.

And I thank all three of you gentlemen for coming promptly and listening to the first hour and 10 minutes of this hearing. I think you have a pretty good sense of what it's all about. We already have one question for you on the record. But before we get to questions, why don't we hear from you on your statements.

STATEMENT OF ROBERT H. ROSWELL, M.D., UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS' AFFAIRS; ACCOMPANIED BY D. MARK CATLETT, PRINCIPAL DEPUTY ASSISTANT SECRETARY FOR MANAGEMENT; AND ROBERT L. NEARY, JR., ASSOCIATE CHIEF FACILITIES MANAGEMENT OFFICER FOR SERVICE DELIVERY

Dr. ROSWELL. Thank you, Mr. Chairman. We're pleased to be here today to appear before the subcommittee.

As you said, with me are Mr. Mark Catlett, our Principal Deputy Assistant Secretary for Management, and Mr. Bob Neary, the Associate Chief Facility Management Officer.

The physical infrastructure of VA health care system remains one of the largest in the Federal Government, with over 5,000 buildings and 150 million square feet inventory. It's been a challenge for VA to maintain this aging infrastructure and to make the improvements necessary to meet the challenges of modern health care.

With the conclusion of the CARES process early next year, it will be critical for the department to promptly address the infrastructure needs identified through that process, as well as pre-existing needs.

I'll briefly discuss the four bills on today's agenda. First, VA wholeheartedly supports H.R. 1720, the Veterans Health Care Facilities Capital Improvement Act, which would authorize the Secretary to carry out construction of certain projects using funds appropriated for fiscal years 2004, '5, and '6 without requiring specific authorization on an individual project basis.

Enactment would accelerate the process for correcting deficiencies in the infrastructure of VA hospitals, and help bring VA hospitals in compliance with existing federal standards. It would also facilitate the future planning of projects and greatly support the CARES process.

VA also supports the intent of H.R. 116 to authorize the Secretary to carry out major medical projects at the site of the former Fitzsimmons Army Medical Center in Aurora, Colorado. The bill provides the Secretary flexibility in selecting the projects by providing that they may include acute, sub-acute, primary, and long-term care services.

We have been involved in evaluating and planning for a facility for the Fitzsimmons site, and there is a strong potential for a joint venture with DOD to provide health care to both veterans and DOD beneficiaries.

A number of issues still remain, including the availability of land, and how that land would be conveyed to the Department of Veterans Affairs. But I'm confident that VA would be able to work with University of Colorado and provide the report to Congress if this bill is enacted.

Regarding H.R. 2307, VA agrees that the need for an expanded replacement outpatient clinic in Columbus is appropriate, as called for in H.R. 2307, and that this will likely be borne out by the CARES study from VISN 10.

The outpatient workload at the existing clinic is increased well beyond the planning level projected when the clinic was open. However, with regard to the other part of H.R. 2307, we feel it's pre-

mature to endorse a new facility proposed in south Texas, and we are currently reviewing the need for additional sites in CARES. Until that effort is complete, we don't have a specific position on a facility in south Texas.

VA supports Sections 1, 2, and 3 of H.R. 2349, and requests that the subcommittee consider the additional project leases requested in the President's fiscal year 2004 budget. These would be authorizations for renewal leases for the Boston outpatient clinic, the Pensacola, Florida, outpatient facility, and a lease renewal for the Health Administration Center in Denver.

VA requests an authorization for a lease instead of construction for the Las Vegas replacement ambulatory care center that Congresswoman Berkley spoke of. VA has determined that a lease can be procured sooner than construction, and that it will reduce the initial funding requirement. We believe that a lease authorization will allow us to complete construction by May of 2006, 3 years from now, and allow us to move into that new comprehensive facility in the most timely manner that best meets the needs of the greater Las Vegas area.

VA also requests that you consider authorizing those seismic projects that were listed in the President's 2003 budget. The facilities in Palo Alto, San Francisco, and west Los Angeles remain at a critical risk to the safety of patients and staff in the case of a seismic event, and remain a high priority for the department. We're confident that the CARES studies will validate the continued need for these major facilities.

Mr. Chairman, the department does not support Section 4 of H.R. 2349, which would prohibit VA from spending funds to dispose of VA's Lakeside property until such time as VA is awarded a contract to construct a new bed tower on VA's Westside campus. VA is proceeding with the design of the bed tower project for Westside, and concurrently taking steps needed to dispose of the Lakeside property as soon as possible through an enhanced-use leasing arrangement. Both projects are critical to VA's successful realignment of health care activities to improve veterans health care in the city of Chicago and the greater metropolitan area, and both need to proceed on a concurrent basis.

Planning and successful execution of real estate disposal in a major urban center like Chicago is time-consuming and complex, taking anywhere from 12 to 20 months, and sometimes longer. A complex enhanced-use project like Lakeside requires VA to take a number of actions before it can actually dispose of the property, including conducting environmental baseline surveys and related activities.

Both activities are now on schedule, and actions are progressing independently without adversely impacting progress of either design or construction of Westside, or planning for the execution of the enhanced-use lease. Delaying these activities until after the scheduled August 2004 construction contract award at Westside would limit the department's ability to use revenues generated by the disposal of Lakeside to fund various aspects of the VISN 12 CARES Implementation Plan.

VA appreciates the subcommittee's interest and actions to improve the infrastructure of VA's health care system. VA's capital

infrastructure has suffered for many years from an uncertainty of the demands and needs for the VA system. I can assure you that there needs to be a strong and viable infrastructure to support veterans health care, and that these bills will enable VA to meet those needs. We look forward to working with the subcommittee to insure that VA continues to fulfill a grateful nation's obligation to care for its veterans.

Mr. Chairman, we would be happy to answer any questions you or the members may have at this point.

[The prepared statement of Dr. Roswell appears on p. 107.]

Mr. SIMMONS. Thank you, Dr. Roswell. I'll be brief, because I know that there's time limitations here. The question came up earlier about increasing the threshold for individual minor construction projects from, I think, 4 million to 10 million. I'd be interested in your comment on that.

And secondly, on the issues of the CARES process generally, I think we've heard that there's wide support for the process, but the process is elongating in some quarters. In the other body, for example, they have suggested that the process is being manipulated in some ways. I think we have legislation before us which empowers the Secretary to make certain discreet decisions with fairly large numbers attached to it.

I'd be interested in your comments generally on the $10 million and on the issue of providing specific authorization for the Secretary in certain areas while, again, this process hopefully comes to a speedy conclusion.

Dr. ROSWELL. Thank you, Mr. Chairman. With regard to the minor construction limitation, generally, we would favor an increase of that limitation. Whether it's 6 million, 8 million, 10 million,—any of those levels would represent additional flexibility in delegated authority to the Secretary.

I would point out that the VISN 12 CARES plan, which is the one completed CARES plan, actually has one of the major provisions currently threatened because of that minor construction threshold at $4 million.

In our north Chicago facility, we had made a commitment to work with the Department of Navy to renovate our ORs in that location. To our surprise, but not dismay, we found that the needed renovations in the ORs would cost slightly over $5 million. We now have no way to authorize that project because of the $4 million threshold. So I would very much favor raising that threshold in H.R. 1720.

I think H.R. 1720 is a wonderful piece of legislation that really recognizes the need to delegate authority and give the Secretary discretion in moving the department forward and addressing specific needs which may occur on a short time line, such as the project in Denver that Mr. Beauprez spoke of. So we support H.R. 1720. We would support the increased threshold.

With regard to extending the time line on CARES, as I reviewed the market plan submitted by the 21 VISNs, I felt that while they addressed a number of critical issues, that other opportunities were not fully addressed. And I asked the VISN directors to readdress certain issues and consider other possible options that might be

considered in crafting the national health care plan to be passed on to the CARES Commission.

While we have extended this phase of the CARES process by approximately 60 days, we'll make up some of that time on the other end of the process. And the Secretary is still fully committed to receiving the CARES Commission final recommendation and making a final decision this calendar year.

With regard to concerns about long-term care being excluded from the CARES process, about domiciliary care being excluded from the process, that is not the case. What we have asked is that in the formulation of all the market plans submitted to me, including the options I've requested of the VISN directors, that we preserve the existing long-term care bed capacity, including nursing home beds, long-term mental health beds, and domiciliary beds.

Where we've asked people to consider the option of consolidating from a two-campus operation to a one-campus operation, or converting a single campus into a 40-hour week operation, as opposed to a 24-by-7 operation, I have specifically instructed them to preserve that bed capacity.

I would point out that long-term care is something that we still need to explore with this committee and the full committee, but that repeatedly, we have found that the cost of new construction is less than the cost of conversion of existing infrastructures, as you yourself pointed out, Mr. Chairman.

I would also point out that trying to house long-term care in a historic hospital building doesn't afford the standard of care, the quality of life, that those veterans deserve. A long-term care resident needs access to the outdoors. They need access to a variety of facilities. And a multi-story facility with limited access to outside recreational opportunities is not ideal.

So consistently and repeatedly, we found that when we need long-term care, it's more desirous to meet ADA requirements, to provide quality of life, as well as the lower construction cost to do that with new construction. And the CARES process will still afford us to expand our long-term care capacity in that manner.

Mr. SIMMONS. Thank you very much for those answers. Mr. Rodriguez.

Mr. RODRIGUEZ. Thank you very much. I think the CARES process showed that there were fewer than 3 percent of the enrollees in the Valley/Coastal Bend market, and that that's, you know, one of the—it is the lowest in the country. And since you very forcefully indicated that you were reluctant to support any construction of any facility there, I was wondering if you had any other options for us there, and especially in the Corpus Christi area, with the Naval base there.

And by the way, the region that I'm referring to is not my area, but it is within the San Antonio area that goes out there. And one of the difficulties that people have understood is, for example, we have Cameron County, you know, that's close to 300 miles away from San Antonio, there's about 20,000 veterans. Hidalgo County, 25,000. Nueces County, which is Corpus Naval, about 32,000 veterans.

Dr. ROSWELL. Yes, Mr. Rodriguez, you're absolutely correct. I think we do have other options. Let me point out for the record

that the CARES process identified many of the deficiencies you have spoke of. It identified what we called access gaps, as well as capacity gaps, for inpatient care in both Nueces County and in Cameron County.

However, one of the CARES criteria, one of the principles is that hospitals—new hospital construction should be a minimum of 100 beds is the general principle, and that we would not seek to own or operate a facility if it had less than 40 beds on an average daily census.

Because of the relatively sparse population density in the area you speak of, we don't meet that critical threshold of 100 beds, nor do we see even a threshold of 40 beds.

Therefore, the other option would be to contract for veterans health care, veterans inpatient health care, in the Cameron County and in the Nueces County area. And we believe that there are sharing partners that would be available to work with the Department of Veterans Affairs to meeting that need for inpatient care in those areas, which you are very correct is an unmet need at present.

Mr. RODRIGUEZ. Thank you.

Mr. SIMMONS. Mr. Beauprez.

Mr. BEAUPREZ. Thank you, Mr. Chairman. Dr. Roswell, good to see you again. I'll try to be quick.

Research has come up repeatedly, and frankly, as a new member of the committee, I'm a little bit embarrassed to say I was very taken when I saw the veterans budget to see the great volume of research that is funded through the VA, and the DOD, for that matter. I shouldn't have been surprised, but I was.

Given that, and understanding why, could you speak for just a minute about the research possibilities as they directly relate to veterans if we were successful in going forward with this Fitzsimmons campus?

Dr. ROSWELL. We have certainly considered research. I believe—and let me point out that many of the issues that were addressed by the previous panel have been fully addressed, and the option currently being favored under consideration. By conveying land to the VA either by a long-term lease or some other arrangement, VA would actually hold title to the bed tower that you spoke of. It would be a VA-owned-and-operated, VA-governed bed tower with a specific VA identity, staffed by VA physicians, VA nurses, VA support staff that would provide comprehensive high-quality care under direct VA management at that location.

However, because of its co-location, it would still allow us to access some of the tertiary care and very specialized services available at that campus without making the capital investment to recreate and duplicate those services. So we're very much in favor of that concept, and believe it's a very viable option.

We've also looked at research space at that location and believe that the most efficient way to acquire needed research space to support the Denver Medical Center's current research portfolio would be to acquire that in a research building planned for construction on the campus, but not in the bed tower we're speaking of. That could be obtained by either leasing that space or purchase,

providing construction funds to build specific space in a new proposed research building at that location.

Mr. BEAUPREZ. Yeah. I understand from my colleague Congressman Hefley's testimony that he submitted, and from other information, that some 90 percent of the docs that now supply the patient care to the VA are part of the University of Colorado Health Science Center, and obviously devoted to research.

Another advantage of the site, if I might just state it for the record, as I'm sure you're aware, a Colorado State veterans nursing home has recently opened literally a stone's throw away from the proposed site.

Now, I haven't said all those wonderful things about why there ought to be a new hospital at Fitzsimmons. What if we're unsuccessful? For the sake of our veterans, what if we can't build this? We've still got a very aged facility, perhaps not quite to the point of my colleague from Nevada, that facility that she described, but a very aged facility that is in bad need of repair. What's Plan B?

Dr. ROSWELL. The Las Vegas Clinic is 6 years old.

Mr. BEAUPREZ. Ours isn't that old.

Dr. ROSWELL. The facility in Denver is 50 years old. So clearly, the facility in Denver is in need of major renovation. We have a tremendous amount of capital investment that must take place in that facility to maintain patient operations at that location.

If we invested in renovating that 50-year-old facility, we would have, in the end, a renovated 50-year-old facility that is no longer located next to its faculty, its house staff, it's medical students, its education, or its research mission. That's why I strongly favor relocating the medical center to the new Fitzsimmons campus, where these collaborative opportunities exist, and I believe significant cost savings could be achieved.

We've also cited a potential VA nursing home facility that's actually adjacent to the state veterans home you spoke of on that campus, and believe that over time, three facilities—a research facility, co-located with the proposed University of Colorado Research Building; a long-term care facility; as well as the acute bed tower—are warranted. I believe H.R. 116 gives us the latitude to pursue all three of those options and support it.

Mr. BEAUPREZ. I appreciate it, and I yield back.

Mr. SIMMONS. I thank the gentleman. Ms. Berkley.

Ms. BERKLEY. Thank you very much, Mr. Chairman. When you're answering the first question that I asked earlier regarding the need for the clinic versus continuing in 10 separate locations, I'd also appreciate—I recall when the Adelaire del Guy facility was first opened. I wasn't in Congress yet, but I attended the celebration. There were flags flying, and speeches were made, and veterans were crying, and we were oohing and ahing as we walked through the facility. And 6 years later, it's condemned.

Now, when we talk about a better deal for the American taxpayer in the long run, if we do a lease, as opposed to actual construction, I just want to make sure when we're leasing this facility—which I agree with you. Whatever gets this done faster so my veterans can move into it faster is fine with me. But if this is the VA's preferred option, what precautions are going to be taken to ensure that the construction of the new facility isn't plagued by the

same structural deficiencies as the building the VA is vacating now? What will we do to insure this never, ever happens again? Not only in Vegas, but anywhere.

Dr. ROSWELL. Let me try to answer your questions in order. To begin with, with the 10 facilities, it would not only be ill-advised, it would be cost-inefficient and inappropriate for the patient care needed. Clearly, the veterans now will receive care in a number of locations simply because we could not identify existing space in a consolidated location to provide the full health care needs of the very significant growth in population in your district.

It was only reluctantly that we sought to acquire a total of 10 facilities, and I would point out at fairly substantial cost, not only in the acquisition cost to lease 10 different sites, but also in the operational cost to provide the security, the maintenance services. It represents a significant inefficiency when you have that distributed.

It's also ill-advised in delivering health care to ask a patient to go to one location, as you pointed out, for certain services, and then have to travel to another location.

So unequivocally, I would be adamantly opposed to having a distributed facility, as opposed to a consolidated comprehensive multispecialty facility where all services available on an ambulatory basis could be obtained at one location.

With regard to the safeguards in the lease mechanism, I'll ask Mr. Neary to specifically address that. But let me point out that even when the current clinic was built, there was some significant concerns that weren't met, and we've learned to regret that decision. We have a very aggressive construction oversight office. Bob, could you address——

Mr. NEARY. Certainly. Thank you. Fortunately, the experience in Las Vegas is unique. But as a result of that, we've made a couple of significant changes in the manner in which we oversee our large leases. The lessor will be required to submit their design documents and drawings to an independent AE firm for a peer review, and will be required to document any necessary changes as a result of that review.

And we've also strengthened our on-site supervision through our resident engineer program to be more closely vigilant to insure that the construction company is constructing the building consistent with the design documents.

Ms. BERKLEY. Thank you very much. I'd just like to thank you very much, Dr. Roswell. It's been a pleasure working with you, and the Secretary. You've been very responsive to our needs.

And also, I think it's important for me to share with you how good a job the VA staff in Las Vegas does keeping all of this together. They have almost insurmountable challenges, and they've managed not only to reach out to the veterans, not only to reach out to the congressional delegation, but they've done a yeoman's job identifying 10 locations. And I know. I was there every step of the way. It was not the choice that we all wanted, but we ended up reluctantly agreeing that that was the only thing to do. And you've implemented it very, very well, and I thank you.

Dr. ROSWELL. Thank you for your understanding and your support, which has been very significant.

Mr. SIMMONS. I thank the lady. Ms. Brown-Waite.

Ms. BROWN-WAITE. Thank you, Mr. Chairman. I just have a basic question as a taxpayer. Is anybody going after the liability of the engineer or the builder or the architect on that building?

Dr. ROSWELL. Yes. The short answer is yes. Bob, do you want to address that?

Mr. NEARY. Yes. Our general counsel is evaluating the options that are available to us, and our Secretary has made it very clear that we'll seek repayment for all the expenses that we're forced to incur because of their failure.

Ms. BROWN-WAITE. Well, I would suggest that you rush this process up. I was involved with a county building that was not built according to plans, that had lots of problems. And two of the counties that I represent, one of them made the time limit that the performance bond and that the surety bond had, and the other one didn't. So I would suggest that you not dawdle too long, or you're liable to miss that reimbursement train.

Dr. ROSWELL. No. Believe me, we have been aggressive in seeking that out. We will suspend lease payments. We'll also look at all the costs associated with the relocation, as well as the cost of the replacement leases in the 10 locations that the other congressman spoke of. And we'll be seeking restitution for all of those expenses from the lessor.

Ms. BROWN-WAITE. Let me ask a question about the CARES plan. When I read through the CARES plan—I think you and I had this discussion—the original draft for the VISN that I amended, VISN 8, we had less than 2 days to respond. Number one, I hope that that wasn't repeated around the nation.

And number two, the assumptions that were in that plan disturbed me. They were assumptions such as, "Well, there will be wealthy veterans moving there." They're veterans. And I think we're losing the focus.

So I have to tell you that as a newcomer, I am very, very concerned about assumptions that go into the CARES plan. To say, "Oh, that's a wealthy area," or "Oh, that's not a wealthy area," we're losing the focus here. They're veterans. So I would like you to address that issue.

And I have a third question for you, and that is when you see in states, whether it's Arizona or Nevada or Florida, where you know veterans are moving to, are you ever in the mode of being forward thinking? And I don't mean to imply that you haven't been. But forward thinking of saying, "Okay, here is a development that is going to have 25,000 retirees. Probably 15,000 of them are going to be veterans. Let's work with that builder and developer. Maybe he or she will donate some land, will work with us."

Because thus far, Doctor, I have a developer who is willing to donate land. He is willing to put up a building and lease it for a dollar a year to get a VA clinic there. And we don't have any response yet. Is this so rare that the private sector steps up and says, "Hey, I'll help you," that your agency doesn't know how to deal with it? Tell me how.

And I can't help but believe Mr. Rodriguez's words of wisdom when I first came on this committee of "You'll get tired of not getting answers."

Dr. ROSWELL. I apologize that you haven't received answers timely. Let me address your question.

Ms. BERKLEY. I haven't received answers.

Dr. ROSWELL. Okay. With regard to the CARES process, it's a very aggressive time line. There's no question about it. We do believe—and—that opinion was expressed on the previous panel, that the time for stakeholder input, including congressional offices, may not have been sufficient in the formulation of the VISN plans. That's part of the reason that I've asked the individual VISN directors to go back and reassess their plans, and in certain cases, to consider additional options that might be considered in that process.

Let me point out that once a national plan is formulated from the individual VISN plans, it will be shared with a CARES Commission, who will be specifically charged by the Secretary to seek extensive stakeholder input. And we certainly hope that that will be an additional opportunity to provide the kind of input you talked about.

With regard to the planning data and looking only at low income or service-connected veterans versus higher-income veterans, you're absolutely right. They're all veterans. And to the extent that resources are made available to the department, they're all entitled to care subject to that availability of resources. That's exactly why the CARES planning data included all eight priorities of veterans in planning the demographic projections, and that was considered in the model.

Finally, with regard to developers providing land to VA, I would point out that the last—the most recent new VA facility in Florida was actually provided on just such an arrangement. A land developer, a developer actually donated 77 acres of land to the VA for the purposes of developing a VA facility in Brevard County. And that site now hosts the Viera outpatient clinic, which is over 100,000 square feet, and is providing state-of-the-art care to veterans in the east central portion of the state.

I realize that's not in your district. But we're very much receptive to those types of opportunities, and we'll certainly work with developers to acquire land on a low-cost basis.

Ms. BROWN-WAITE. Mr. Chairman, if I might, I know I've exceeded my time, but just one follow-up question.

Mr. SIMMONS. Please.

Ms. BROWN-WAITE. Dr. Roswell, you don't seem to understand. He not only will donate the land; he will construct the building according to VA standards. If only someone from the VA would get back to this man. My office has been waiting. This developer has been waiting.

Dr. ROSWELL. That's in the Villages area?

Ms. BROWN-WAITE. Yes, sir, it is.

Dr. ROSWELL. I am familiar with that, and it is being carefully looked at.

Ms. BROWN-WAITE. But no one has contacted him.

Dr. ROSWELL. I'll be happy to check into that.

Ms. BROWN-WAITE. Thank you.

Mr. SIMMONS. I thank the lady. Does the contractor have any land in south Texas, by any chance?

(Laughter.)

Mr. SIMMONS. I want to thank the panel for being here. I will just share with you, Dr. Roswell, that I've been in government for quite a while. Whenever I hear the word "process," it makes me nervous, you know?

I served in Vietnam, and when a helicopter went down, the people on the ground didn't want to hear about the "process" of recovery. They wanted, you know, the search and rescue guys to get out there and get them out.

And when you go to an emergency room, you probably really don't want to hear about the "process" of how you're going to be treated. "Hey, Doc, take care of me. Fix me up. Get me out of here."

And for those of us who represent fairly substantial veterans populations, as we begin to hear about the CARES process and the fact that the process is being extended, the deadline is being extended, we're getting that nervous feeling. And that's, I think, what you've probably been hearing about a little bit today.

That being said, I believe, and I think members of the committee believe, that we have some legislation before us which is important which does not degrade or undermine the CARES process—in fact, enhances and facilitates it—that we have some specific projects in various parts of the country that deserve to be moved in a timely fashion, and we're interested in doing that.

It would be my intent to move these bills in a regular order, which means to get them forward to a markup, hopefully as soon as June 24, which is when the subcommittee does plan a business meeting. And I call upon my colleagues on both sides of the aisle to work together to see if we can reach agreement on as much of this legislation as we can.

That being said, we will have some additional questions for the record. And unless any of my colleagues have additional comments they would like to make. And hearing none, this hearing is adjourned. Thank you, everybody.

[Whereupon, at 3:40 p.m., the subcommittee was adjourned.]

APPENDIX

I

108TH CONGRESS
1ST SESSION

H. R. 1720

To authorize the Secretary of Veterans Affairs to carry out construction projects for the purpose of improving, renovating, establishing, and updating patient care facilities at Department of Veterans Affairs medical centers.

IN THE HOUSE OF REPRESENTATIVES

APRIL 10, 2003

Mr. SIMMONS (for himself and Mr. SMITH of New Jersey) introduced the following bill; which was referred to the Committee on Veterans' Affairs

A BILL

To authorize the Secretary of Veterans Affairs to carry out construction projects for the purpose of improving, renovating, establishing, and updating patient care facilities at Department of Veterans Affairs medical centers.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Veterans Health Care Facilities Capital Improvement Act".

SEC. 2. AUTHORIZATION OF MAJOR MEDICAL FACILITY PROJECTS FOR PATIENT CARE IMPROVEMENTS.

(a) IN GENERAL.—(1) The Secretary of Veterans Affairs is authorized to carry out major medical facility projects in accordance with this section, using funds appropriated for fiscal year 2004, 2005, or 2006 pursuant to section 3. The cost of any such project may not exceed

(A) $100,000,000 in fiscal year 2004;

(B) $125,000,000 in fiscal year 2005; and

(C) $150,000,000 in fiscal year 2006.

(2) Projects carried out under this section are not subject to section 8104(a)(2) of title 38, United States Code.

(b) TYPE OF PROJECTS.—A project carried out under subsection (a) may be carried out only at a Department of Veterans Affairs medical center and only for the purpose of one or more of the following:

(1) Improving a patient care facility.

(2) Replacing a patient care facility.

(3) Renovating a patient care facility.

(4) Updating a patient care facility to contemporary standards.

(5) Establishing a new patient care facility at a location where no Department patient care facility exists.

(6) Improving, replacing, or renovating a research facility or updating such a facility to contemporary standards.

(c) PURPOSE OF PROJECTS.—In selecting medical centers for projects under subsection (a), the Secretary shall select projects to improve, replace, renovate, update, or establish facilities to achieve one or more of the following:

(1) Seismic protection improvements related to patient safety (or, in the case of a research facility, patient or employee safety).

(2) Fire safety improvements.

(3) Improvements to utility systems and ancillary patient care facilities (including such systems and facilities that may be exclusively associated with research facilities).

(4) Improved accommodation for persons with disabilities, including barrier-free access.

(5) Improvements at patient care facilities to specialized programs of the Department, including the following:

(A) Blind rehabilitation centers.

(B) Inpatient and residential programs for seriously mentally ill veterans, including mental illness research, education, and clinical centers.

(C) Residential and rehabilitation programs for veterans with substance-use disorders.

(D) Physical medicine and rehabilitation activities.

(E) Long-term care, including geriatric research, education, and clinical centers, adult day care centers, and nursing home care facilities.

(F) Amputation care, including facilities for prosthetics, orthotics programs, and sensory aids.

(G) Spinal cord injury centers.

(H) Traumatic brain injury programs.

(I) Women veterans' health programs (including particularly programs involving privacy and accommodation for female patients).

(J) Facilities for hospice and palliative care programs.

(d) REVIEW PROCESS.—(1) The Secretary shall provide that, before a project is submitted to the Secretary with a recommendation that it be approved as a project to be carried out under the authority of this section, the project shall be reviewed by a board within the Department of Veterans Affairs that is independent of the Vet-

erans Health Administration and that is constituted by the Secretary to evaluate capital investment projects. The board shall review such project to determine the project's relevance to the medical care mission of the Department and whether the project improves, renovates, repairs, establishes, or updates facilities of the Department in accordance with this section.

(2) In selecting projects to be carried out under the authority provided by this section, the Secretary shall consider the recommendations of the board under paragraph (1). In any case in which the Secretary approves a project to be carried out under this section that was not recommended for such approval by the board under paragraph (1), the Secretary shall include in the report of the Secretary under section 4(b) notice of such approval and the Secretary's reasons for not following the recommendation of the board with respect to that project.

SEC. 3. AUTHORIZATION OF APPROPRIATIONS.

(a) IN GENERAL.—There are authorized to be appropriated to the Secretary of Veterans Affairs for the Construction, Major Projects, account for projects under section 2—

(1) $500,000,000 for fiscal year 2004;

(2) $600,000,000 for fiscal year 2005; and

(3) $700,000,000 for fiscal year 2006.

(b) LIMITATION.—Projects may be carried out under section 2 only using funds appropriated pursuant to the authorization of appropriations in subsection (a), except that funds appropriated for advance planning may be used for the purposes for which appropriated in connection with such projects.

SEC. 4. REPORTS.

(a) GAO REPORT.—Not later than April 1, 2005, the Comptroller General shall submit to the Committees on Veterans' Affairs and on Appropriations of the Senate and House of Representatives a report evaluating the advantages and disadvantages of congressional authorization for projects of the type described in section 2(b) through general authorization as provided by section 2(a), rather than through specific authorization as would otherwise be applicable under section 8104(a)(2) of title 38, United States Code. Such report shall include a description of the actions of the Secretary of Veterans Affairs during fiscal year 2004 to select and carry out projects under section 2.

(b) SECRETARY REPORT.—Not later than 120 days after the date on which the site for the final project under section 2 for each such fiscal year is selected, the Secretary shall submit to the committees referred to in subsection (a) a report on the authorization process under

section 2. The Secretary shall include in each such report the following:

(1) A listing by project of each such project selected by the Secretary under that section, together with a prospectus description of the purposes of the project, the estimated cost of the project, and a statement attesting to the review of the project under section 2(c), and, if that project was not recommended by the board, the Secretary's justification under section 2(d) for not following the recommendation of the board.

(2) An assessment of the utility to the Department of Veterans Affairs of that authorization process.

(3) Such recommendations as the Secretary considers appropriate for future congressional policy for authorizations of major and minor medical facility construction projects for the Department of Veterans Affairs.

(4) Any other matter that the Secretary considers to be appropriate with respect to oversight by Congress of capital facilities projects of the Department of Veterans Affairs.

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108TH CONGRESS
1ST SESSION

H. R. 116

To authorize the Secretary of Veterans Affairs to construct, lease, or modify major medical facilities at the site of the former Fitzsimons Army Medical Center, Aurora, Colorado.

IN THE HOUSE OF REPRESENTATIVES

JANUARY 7, 2003

Mr. HEFLEY (for himself, Mr. UDALL of Colorado, Mr. MCINNIS, Mrs. MUSGRAVE, Mr. TANCREDO, Mr. BEAUPREZ, and Ms. DEGETTE) introduced the following bill; which was referred to the Committee on Veterans' Affairs

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A BILL

To authorize the Secretary of Veterans Affairs to construct, lease, or modify major medical facilities at the site of the former Fitzsimons Army Medical Center, Aurora, Colorado.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Veterans' New Fitzsimons Health Care Facilities Act of 2003".

SEC. 2. AUTHORIZATION OF MAJOR MEDICAL FACILITY PROJECTS, FORMER FITZSIMONS ARMY MEDICAL CENTER, AURORA, COLORADO.

(a) AUTHORIZATION.—The Secretary of Veterans Affairs may carry out major medical facility projects under section 8104 of title 38, United States Code, at the site of the former Fitzsimons Army Medical Center, Aurora, Colorado. Projects to be carried out at such site shall be selected by the Secretary and may include inpatient and outpatient facilities providing acute, sub-acute, primary, and long-term care services. Project costs shall be limited to an amount not to exceed a total of $300,000,000 if a combination of direct construction by the Department of Veterans Affairs and capital leasing is selected under subsection (b) and no more than $30,000,000 per year in capital leasing costs if a leasing option is selected as the sole option under subsection (b).

(b) SELECTION OF CAPITAL OPTION.—The Secretary of Veterans shall select the capital option to carry out the authority provided in subsection (a) of either—

(1) direct construction by the Department of Veterans Affairs or a combination of direct construction and capital leasing; or

(2) capital leasing alone.

(c) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to the Secretary of Veterans

Affairs for fiscal years 2004, 2005, and 2006 for "Construction, Major Projects" for the purposes authorized in subsection (a)—

(1) a total of $300,000,000, if direct construction, or a combination of direct construction and capital leasing, is chosen pursuant to subsection (b) for purposes of the projects authorized in subsection (a); and

(2) $30,000,000 for each such fiscal year, if capital leasing alone is chosen pursuant to subsection (b) for purposes of the projects authorized in subsection (a).

(d) LIMITATION.—The projects authorized in subsection (a) may only be carried out using—

(1) funds appropriated for fiscal year 2004, 2005, or 2006 pursuant to the authorization of appropriations in subsection (a);

(2) funds appropriated for Construction, Major Projects, for a fiscal year before fiscal year 2004 that remain available for obligation; and

(3) funds appropriated for Construction, Major Projects, for fiscal year 2004, 2005, or 2006 for a category of activity not specific to a project.

(e) REPORT TO CONGRESSIONAL COMMITTEES.—Not later than 120 days after the date of the enactment of

this Act, the Secretary shall submit to the Committees on Appropriations and the Committees on Veterans' Affairs of the Senate and House of Representatives a report on this section. The report shall include notice of the option selected by the Secretary pursuant to subsection (b) to carry out the authority provided by subsection (a), information on any further planning required to carry out the authority provided in subsection (a), and other information of assistance to the committees with respect to such authority.

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108TH CONGRESS
1ST SESSION

H. R. 2307

To provide for the establishment of new Department of Veterans Affairs medical facilities for veterans in the area of Columbus, Ohio, and in south Texas.

IN THE HOUSE OF REPRESENTATIVES

JUNE 3, 2003

Mr. HOBSON (for himself, Mr. ORTIZ, Ms. PRYCE of Ohio, Mr. TIBERI, Mr. GILLMOR, Mr. RODRIGUEZ, Mr. REGULA, Mr. REYES, and Mr. OXLEY) introduced the following bill; which was referred to the Committee on Veterans' Affairs

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A BILL

To provide for the establishment of new Department of Veterans Affairs medical facilities for veterans in the area of Columbus, Ohio, and in south Texas.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. NEW DEPARTMENT OF VETERANS AFFAIRS MEDICAL FACILITY, COLUMBUS, OHIO.

(a) PROJECT AUTHORIZATION.—The Secretary of Veterans Affairs is authorized to construct a medical facility on available Federal land at the Defense Supply Center, Columbus, Ohio.

(b) FUNDING.—There are authorized to be appropriated to the Secretary of Veterans Affairs $90,000,000 for the purposes of subsection (a).

SEC. 2. NEW DEPARTMENT OF VETERANS AFFAIRS MEDICAL FACILITY, SOUTH TEXAS.

(a) PROJECT AUTHORIZATION.—The Secretary of Veterans Affairs is authorized—

(1) to acquire a site in south Texas suitable for a medical facility; and

(2) to construct a medical facility on that site.

(b) FUNDING.—There are authorized to be appropriated to the Secretary of Veterans Affairs such sums as may be necessary for the purposes of subsection (a), except that the amount appropriated for the construction of the medical facility may not exceed the amount equal to the product of (1) the number of patient beds to be provided in the facility, and (2) $290,000.

SEC. 3. MEDICAL FACILITY DEFINED.

For the purposes of this Act, the term "medical facility" has the meaning given that term in section 8101(3) of title 38, United States Code.

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108TH CONGRESS
1ST SESSION

H. R. 2349

To authorize certain major medical facility projects for the Department of Veterans Affairs.

IN THE HOUSE OF REPRESENTATIVES

JUNE 5, 2003

Mr. EVANS (for himself, Mr. SIMMONS, Mr. GUTIERREZ, Mr. FILNER, Ms. BERKLEY, and Mrs. DAVIS of California) introduced the following bill; which was referred to the Committee on Veterans' Affairs

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A BILL

To authorize certain major medical facility projects for the Department of Veterans Affairs.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. AUTHORIZATION OF MAJOR MEDICAL FACILITY PROJECTS.

The Secretary of Veterans Affairs may carry out the following major medical facility projects, with each project to be carried out in the amount specified for that project:

(1) Construction of a new bed tower to consolidate two inpatient sites of care in inner city Chicago at the West Side Division of the Department of Vet-

erans Affairs health care system in Chicago, Illinois, in an amount not to exceed $98,500,000.

(2) Construction in Clark County, Nevada, of a facility for (A) a multispecialty outpatient clinic to replace the leased Las Vegas ambulatory care center, and (B) a satellite office for the Veterans Benefits Administration, in an amount not to exceed $97,300,000.

(3) Seismic corrections to strengthen Medical Center Building 1 of the Department of Veterans Affairs health care system in San Diego, California, in an amount not to exceed $48,600,000.

(4) A project for (A) renovation of all inpatient care wards at the West Haven, Connecticut, facility of the Department of Veterans Affairs health system in Connecticut to improve the environment of care and enhance safety, privacy, and accessibility, and (B) establishment of a consolidated medical research facility at that facility, in an amount not to exceed $50,000,000.

SEC. 2. AUTHORIZATION OF APPROPRIATIONS.

(a) IN GENERAL.—There is authorized to be appropriated to the Secretary of Veterans Affairs for fiscal year 2004 for the Construction, Major Projects, account $294,400,000 for the projects authorized in section 1.

(b) LIMITATION.—The projects authorized in section 1 may only be carried out using—

(1) funds appropriated for fiscal year 2004 pursuant to the authorization of appropriations in subsection (a);

(2) funds appropriated for Construction, Major Projects, for a fiscal year before fiscal year 2004 that remain available for obligation; and

(3) funds appropriated for Construction, Major Projects, for fiscal year 2004 for a category of activity not specific to a project.

SEC. 3. AUTHORIZATION OF MAJOR MEDICAL FACILITY LEASE.

The Secretary of Veterans Affairs may enter into a lease for an outpatient clinic in Charlotte, North Carolina, in an amount not to exceed $3,000,000.

SEC. 4. LIMITATION ON DISPOSAL OF LAKESIDE DIVISION, DEPARTMENT OF VETERANS AFFAIRS MEDICAL FACILITIES, CHICAGO, ILLINOIS.

(a) LIMITATION.—No funds available to the Secretary of Veterans Affairs may be used for disposal of the Lakeside Division facility of the Department of Veterans Affairs medical facilities in Chicago, Illinois, until the Secretary has entered into a contract to construct a new bed

tower at the West Side Medical Center of the Department of Veterans Affairs in Chicago, Illinois.

(b) DEFINITION.— For purposes of this section, the term "disposal", with respect to the Lakeside Division facility, includes entering into a long-term lease or sharing agreement under which a party other than the Secretary has operational control of the facility.

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Honorable Rob Simmons
Chairman, Subcommittee on Health
Veterans' Affairs Committee

Opening Statement
Legislative Hearing on Capital Improvements to
Veterans Health Care Facilities
Wednesday, June 11, 2003

Good afternoon, the Subcommittee will come to order.

Welcome the witnesses and Members present. Before we move on, without objection, I'd like to enter into the record several statements from Congressman David Hobson of Ohio; Congressman Joel Hefley of Colorado; Congressman Solomon Ortiz of Texas; Congresswoman Deborah Pryce of Ohio; and Congressman Lane Evans, Ranking Member of our Committee.

Important topic before the Subcommittee today. The purpose of today's legislative hearing is to authorize the Secretary of Veterans Affairs to carry out several major construction projects, improve, renovate and update patient care facilities at various VA medical centers.

We will be discussing four (4) bills:

H.R. 1720 (Simmons), the Veterans Health Care Facilities Capital Improvement Act, authorizes the Secretary of VA to carry out major medical facility projects, using funds appropriated for fiscal years 2004 through 2006.

H.R. 116 (Hefley), Veterans' New Fitzsimmons Health Care Facilities Act of 2003, a bill to authorize relocation of the Denver VA Medical Center to the old Fitzsimons Army Hospital site.

H.R. 2349 (Evans), a bill to fund construction of a new bed tower at the West Side facility in Chicago, funding for a project to replace the existing ambulatory care center in Las Vegas, to address seismic corrections at the San Diego VA Medical Center, to renovate inpatient wards and research facilities at West Haven, Connecticut, VA Medical Center, and a major lease for a new clinic in Charlotte, North Carolina.

H.R. 2307 (Hobson), would provide for the establishment of new VA medical facilities in the area of Columbus, Ohio and in south Texas, and Capital improvement in VA health care is a matter of ongoing frustration to the Committee, and seriously troubling for a number of VA facilities that are in dire need of repairs and restoration to ensure that our nation's veterans are provided quality care in safe and functional settings.

The physical infrastructure of the VA health care system is one of the largest in the federal government--with over 4,700 buildings. Much of this medical structure was built over 50 years ago and is now substandard and in many instances crumbling. The severity of the problems include buildings in danger of collapsing in earthquakes—like the damaged patient care buildings 6 and 91 on the campus of the American Lake VA Medical Center in 2001 and the Martinez VAMC that was completely closed about ten years ago.

As Members of this Committee, I believe we are all painfully aware that VA's investment in its health care facilities infrastructure has been unsatisfactory in recent years. This problem is laid at the feet of VA's planning initiative called CARES (Capital Asset Realignment for Enhanced Services).

CARES, as I understand it, was designed to evaluate VA health care services and identify ways to realign its medical facilities to meet the future health care needs of veterans. The point is supposed to be "to enhance services."

VA has been reluctant to commit to capital investment until this CARES process to be completed to avoid inappropriately spending funds on VA facilities that will not be needed in the future.

The CARES process, however, will not be concluded any time soon. In fact, on Monday of last week, (June 2), the Secretary announced that the CARES plan timetable has been extended for 30 days to give VHA more time to review the Draft National plan. I know in my own district, the West Haven VAMC is an impressive facility from the outside, sitting prominently atop a small hill overlooking the city. On the inside, however, it's a completely different story. The main structure, built in 1950, shows its age. It's worn, drab and dull with a few exceptions. There is an acute need to renovate the med/surg, Intensive Care Units and mental health wards. There are three 30-bed units and an 8-bed dialysis bay without partition, all of which are cluttered, dingy and seedy, and involve some amenities most people have not seen in hospitals in 30 years.

This rundown, outdated facility is one of Yale Medical School's major affiliates, full of Yale residents, researchers, medical students and interns, with an accompanying $30 million annual research budget, the only impact on West Haven I see from CARES is to further delay and cause more local deterioration.

As VA continues to operate without construction funding, reports from both outside consultants and VA show a mounting need and rising backlog of major projects. I ask my colleagues to please look at the charts provided to you that graphically illustrate in RED the minimum spending level that Price Waterhouse recommended in its 1998 study to maintain VA's multi-billion dollar capital assets versus actual spending for both major and minor construction projects in GREEN. The cumulative affect of years of under-funding has contributed to an estimated $6 billion in construction funding deficits, using Price Waterhouse's 4 percent Plant Replacement Value as a minimum standard. The Committee believes Congress must act to provide some level of funding to support at least part of VA's construction needs to ensure our veterans are cared for in safe and reliable environments. The President's FY '04 budget request includes $422.3 million for major and minor construction, and the Congressional Resolution on the '04 budget assumes we will spend $500 million on these needs.

We have a lot of ground to cover, so let me recognize my friend and Ranking Member, Mr. Rodriguez of Texas. Do you have an opening statement?

OPENING STATEMENT FOR THE RECORD
LUIS V. GUTIERREZ
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH

Hearing on H.R. 1720, Veterans Health Care Facilities Capital Improvement Act; H.R. 116, Veterans' New Fitzsimons Health Care Facilities Act of 2003; H.R. 2307, to provide for the establishment of new VA medical facilities for veterans in the area of Columbus, OH, and in south TX; and H.R. 2349, to authorize certain major medical facility projects for VA.
Wednesday, June 11, 2003, 2:00 p.m.
334 Cannon House Office Building

Thank you, Mr. Chairman, for holding this very important hearing on VA's major construction projects. I would also like to extend my gratitude to the witnesses testifying before us today.

Several VA patient care facilities are in dire need of renovations and repairs, but face unacceptable delays in moving forward on these improvements. The Capital Asset Realignment for Enhanced Services (CARES) process has essentially held the most urgent construction projects hostage, effectively placing the very goal of CARES-- to make efficient use of physical assets to improve health care for veterans-- in danger.

Our nation's veterans, who have risked their lives in defense of our freedoms and who have been promised and have earned access to quality health care from VA, should not have to receive health services in outdated, even decrepit and dangerous, health care facilities.

Allow me to express my concern by way of an example from my district in Chicago, located in VISN 12 of the Illinois-Wisconsin network, where the CARES process was initially piloted.

Phase I of CARES resulted in the closure of inpatient services at VA's Lake Side Medical Center and the consolidation of inner-city Chicago's inpatient services for veterans at the West Side Division. Chicago veterans tentatively supported this reconfiguration of health care services based upon VA's commitment to enhance these services. Thus far, however, the Administration has failed to request the $98.5 million required to construct this essential inpatient tower at VA Chicago's West Side Division.

I can not comprehend how patient services for veterans will be improved without the Administration seeking funding for the very projects the CARES process recommends.

I have been informed that VA hopes to use funds raised from entering a long-term "enhanced-use lease" for the property at Lake Side to build the planned West Side tower. However, estimates of the market value of Lake Side vary widely with regard to issues of zoning and proposed use of

the site. In fact, I believe VA is at risk of breaking its promise of enhanced services for the 654,000 veterans in the Chicago area by speculating on the highest bid VA hopes to receive for the use of the Lake Side property.

Are these the kinds of results the rest of the nation can look forward to as a result of the CARES process? Until the promise of CARES is realized in Chicago and the surrounding area, I find it difficult to support the use of Phase I as the prototype for the rest of the nation.

Given the Administration's inaction to seek funding for its own CARES recommendations in Chicago, I urge my colleagues and this Committee to support Mr. Evan's legislation, H.R. 2349, a bill that, among other important things, would authorize the construction of a new bed tower at VA's West Side Medical Center. I would also like to respectfully ask the VA to do everything in its power to support this important legislation, ensure funding for the West Side patient tower, and most importantly, follow through on its promise of enhanced services for veterans.

Thank you, Mr. Chairman, and I thank the witnesses again and look forward to their testimony.

Lane Evans
Extension of Remarks
Assured Funding for Veterans Health Care Act of 2003
June 4, 2003

Today, on behalf of myself and 75 of my colleagues, I am introducing H.R. 2318, the "Assured Funding for Veterans Health Care Act of 2003." Starting in Fiscal Year 2005, the bill would require the Secretary of the Treasury to provide funding for the Department of Veterans Affairs Health Care System based on the number of enrollees in the system and the consumer price index for hospital and related services. I believe the measure I am offering will create a vastly improved funding system that better responds to the needs of our veterans.

Last week the President's Task Force to Improve Health Care Delivery For Our Nation's Veterans issued its final report. In it, the "growing mismatch between funding and demand" is repeatedly referenced. To address this problem, the report recommended:

> The Federal Government should provide full funding to ensure that enrolled veterans in Priority Groups 1 through 7 (new) are provided the current comprehensive benefit in accordance with VA's established access standards. Full funding should occur through modifications to the current budget and appropriations process, by using a mandatory funding mechanism, or by some other changes in the process that achieve the desired goal. (p. 77)

In addition, the Task Force addressed the need to clarify standards of access for Priority 8 veterans. Priority 8 veterans are the so-called "high-income" veterans without compensable service-connected conditions. Who are these individuals? Anyone with an income level of more than the geographically adjusted Housing and Urban Development threshold for low-income housing is considered "high income". In some communities, this means veterans with incomes of more than $24,644—most often work-a-day folks who sometimes have to choose between prescription drugs and heat or groceries. My bill would cover these veterans.

Some will say that we've done well by our veterans this year. I would say it might well have gone the other way. This body passed a budget resolution that would have required us to cut veterans benefits during a period of war. It still remains unclear how veterans' health care will fare when pitted against such disparate programs as low-income housing, the

space program and other independent agencies. Other health programs such as Medicare and TRICARE for Life are not subject to the same types of considerations because funding for these programs is based on need.

The result of this funding process is the "growing mismatch" addressed by the President's task force—the system is starving! We all have heard the numbers of veterans who have waited more than six months for health care services. There were more than 200,000 veterans in the queue at the beginning of the year. Even with increases proposed in the joint budget resolution, VA will still impose some regulatory constraints on access and has identified more than a billion in illusory "management efficiencies."

Last year, I cosponsored H.R. 5250, the "Veterans Health Care Funding Guarantee Act of 2002" with 129 other members of the House. The bill I am offering today closely resembles that legislation. The Congressional Budget Office slapped a hefty price tag on H.R. 5250 largely assuming huge increases in demand would result if the veterans' health care system were adequately funded! Think about this—our budget office assumes that our health care system for veterans is so fiscally deprived that a fairer funding system that responds to changes in demand would create a run on health care!

Our veterans deserve better than a chronically underfunded health care system. I believe veterans—all veterans—have earned the right to access the health care system that was created to serve their needs. The price we pay as a Nation for assuring timely access to high-quality health care services is small in relation to the price we have asked them to pay in securing our freedom.

I urge my colleagues to join me and the 75 other members of the House that believe this is the right thing to do for our veterans. Every major veterans service organization, including The American Legion, Disabled American Veterans, and Veterans of Foreign Wars, has stated support for this bill. Join us in the fight to do the right thing for our veterans. Join me in cosponsoring the "Assured Funding for Veterans Health Care Act of 2003".

Statement- Mr. Beauprez:

Thank You Mr. Chairman. I am extremely pleased the subcommittee is holding a hearing on the authorization of construction projects within the Department of Veterans affairs. As you know, I represent the area where HR 116, if passed through Congress, would relocate the Denver VA Medical Center to the Old Fitzsimmons Army Site in Aurora, Colorado. I strongly support this bill and this relocation project. I truly believe that the University of Colorado Hospital and Health Sciences Center has created a state of the art medical community at the Fitzsimmons site. Relocating the Denver VAMC to Fitzsimmons would create an unprecedented opportunity to create a partnership between a veteran's medical center, a Department of Defense hospital and a major academic medical center.

The current Denver VA medical facility is over 50 years old and in dire need of repairs and upgrades. It would require millions of dollars to maintain and renovate the hospital to current standards. It would be fiscally irresponsible to use taxpayer's dollars to overhaul an already substandard facility when a new hospital can be built at a lower cost in the long run. With the new facility, many traffic, neighborhood, parking and congestion issues will be solved as well.

The Fitzsimons campus is a flourishing medical site and is well suited for the Denver VA Medical Center This is a remarkable opportunity to increase sharing and collaboration. Mr. Hefley from our good state of Colorado and I, along with the entire Colorado delegation are committed to this relocation project. I would like to recognize the statement submitted for the record today by Mr. Hefley. Mr. Hefley adequately outlines and addresses the concerns Secretary Principi has

stated regarding H.R. 116. I agree with Mr. Hefley's statement, and have also visited with Secretary Principi, Under Secretary Mackay, and other key staff at the VA about our shared concerns.

My end goal is to ensure veterans in Colorado have the highest quality medical care in the best facilities possible. No single issue has received such overwhelming support and encourage from the VSO's and individual veterans in my district than the relocation of the aged Denver VA to the

Fitzsimons Campus. It is our responsibility to find ways to provide the best healthcare possible at the most efficient cost to the taxpayer. In my view, H.R. 116 is common sense legislation to solve the dilemma of the deteriorating Veterans Medical Center in Denver- there is no better time than now to enact the relocation project.

CONGRESSMAN DAVID HOBSON
Prepared Testimony in Support of H.R. 2307
June 11, 2003

Mr. Chairman, I rise in support of legislation I recently introduced in conjunction with Congressman Ortiz, Congresswoman Pryce, Congressman Tiberi and several Members of the Ohio and Texas delegations.

As a Member of the VA, HUD, and Independent Agencies Appropriations Subcommittee, which has jurisdiction over much of the VA's funding, I was very pleased to learn that the Subcommittee on Health of the House Veterans' Affairs Committee has agreed to consider this important legislation, which would authorize the construction of two new and critically needed VA medical facilities in Central Ohio and Southern Texas.

The estimated 250,000 veterans now living in Central Ohio are in an undesirable situation. The Capital Asset Realignment for Enhanced Services (CARES) access analysis shows that a significant gap exists for primary and specialty care for the veterans living in Central Ohio.

The current Chalmers P. Wylie VA Outpatient Clinic in Columbus has a high quality, professional medical staff, but the facility itself is inadequate for the needs of area veterans. Originally, this clinic was to handle 135,000 annual visits, but last year it saw more than 192,000. Over the years, far too many veterans have had to travel for many hours to larger VA medical centers in Cleveland, Cincinnati and elsewhere because of the limited services offered by the current 118,000-square-foot clinic. The cost to transfer these veterans has reached several million dollars per year.

Furthermore, this clinic is not on federal land, and the VA does not own the facility. Its lease, which is from a private company at significant cost to the taxpayers, is set to expire in 2014 resulting in an uncertain future for Ohio's veterans.

The 260,000-square-foot clinic proposed by this legislation, which is estimated to cost $65 million to construct and $25 million to equip, will be located on available federal land at the Defense Supply Center, Columbus (DSCC). A new facility on this site would not require any land acquisition costs and would pave the way for potential Department of Defense / VA sharing, which is a House priority as evidenced by the recent 426 to 0 passage of H.R. 1911, to enhance cooperation between the two agencies.

And most important, the new clinic will have greater total patient capacity and offer a much wider array of medical services for the veterans of Central Ohio.

As a veteran, I am proud to support this legislation, which addresses the needs of veterans in both Ohio and Texas.

Mr. Chairman, I join today with my colleagues, and veterans across Ohio and Texas in support of this legislation.

Dave Hobson

DAVID L. HOBSON
Member of Congress

JOEL HEFLEY
COLORADO
FIFTH DISTRICT

COMMITTEES
ARMED SERVICES
STANDARDS OF
OFFICIAL CONDUCT
CHAIRMAN

Congress of the United States
House of Representatives

Statement of the Honorable Joel Hefley

To the House Committee on Veterans Affairs, Subcommittee on Health
Legislative Hearing on Major VA Medical Facility Construction Projects
June 11, 2003

Mr. Chairman, Ranking Member Rodriguez and Members of the Subcommittee on Health, thank you for this opportunity to provide the committee with my prepared testimony for the record for today's hearing on the Department of Veterans Affairs (VA) medical facility construction projects, and my legislation, H.R. 116.

Mr. Chairman, since the end of WWII the Denver Veterans Medical Center (DVMC), the University of Colorado Health Sciences Center (UCHSC) and the University of Colorado Hospital (UCH) have been in partnership at the University's campus in Denver. This partnership has included the significant sharing of resources, including physician faculty, house staff, facilities, equipment, supplies and services, as well as the long-term mission of education, research, patient care and community service.

Today, some 90 percent of the physicians who are treating veterans in the VA Medical Center are shared with the University of Colorado Health Sciences Center and nearly all of them are on the faculty of the Medical School. From the beginning, the two hospitals have shared expensive, and specialized medical equipment and facilities, such as surgical suites and imaging equipment. For example, veterans who need a liver transplant have it done at the University of Colorado Hospital.

Due to the lack of space, inability to renovate or construct newer facilities and the cost associated with continuing to use the site, in 1995 the UCH determined that its Denver campus was no longer compatible with its long-term mission. The closure of the Fitzsimons Army Medical Center in Aurora, Colorado provided the UCH with the opportunity to move to a new site, four and one half times the size of the existing campus, and to build a medical complex for the 21st century.

To date, the development of the new 217 acre campus includes completion of the outpatient and cancer pavilions, an eye institute, the first library building and a central power plant. Construction is underway on the first phase of the hospital, biomedical and cancer research towers, and the Native American building. Additionally, The Children's Hospital in Denver has agreed to relocate to the Fitzsimons campus. The total project is currently estimated at $1.7 billion, for which almost half of the funds have been secured.

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While the move to Fitzsimons solved existing problems and provided future advantages for UCH, it also separated the Denver Veterans Medical Center from both the UCHSC and UCH. Unfortunately, a separation of more than eight miles creates a significant barrier to continued quality care for veterans who receive their care at the DVMC.

Compounding this problem, a recent study commissioned by the Veterans Integrated Service Network (VISN) 19 indicated that high demand by veterans at the DVMC will continue unabated for the next 20 years. The cost of maintaining the current DVMC to satisfy minimal accreditation levels until 2020 has been estimated to be $233 million, and estimates to rebuild the facility in 2020 are $377 million in today's dollars.

As the Committee may be aware of, officials with the University of Colorado Hospital, as well as Senator Ben Nighthorse Campbell and myself have met with the Secretary of Veterans Affairs, Secretary Anthony Principi, on several occasions to discuss this issue. Through the course of these meetings, Secretary Principi indicated four primary concerns about this partnership: veterans' "identity"; Department of Veterans Affairs governance; VA union employees; and the $300 million cost having to be diverted from patient care. Mr. Chairman, I would like to address each of the Secretary's concerns for the Subcommittee.

First, with regard to the Secretary's concerns about veterans' "identity" and VA governance, I want to assure the Committee that the University of Colorado, the local Veterans' Service Organizations as well as the entire Colorado congressional delegation support this goal. We are on record as advocating for a separate identity and will work to accomplish this objective. The VA must remain in control of and be totally responsible for, the care veterans receive in the new VA Medical Center. All of the specialized programs for veterans must continue and the Federally employed VA workforce must be permitted the autonomy to carry out their mission under Title 38.

Mr. Chairman, it is envisioned that the basic elements of a new VA Medical Center at Fitzsimons would include a free-standing ambulatory, and inpatient care federal tower building for veterans, clearly identified as the Veterans Administration Medical Center with its own nearby parking. New VA research facilities would be constructed. There would be a new VA long-term care unit located next to the new 180-bed State veterans nursing home currently being constructed at the site.

With regard to the issue of federal employees, let me just say that all parties involved are very sensitive to the issue of the rights of VA federal employees. With the advent of a separate federal tower, all the employees caring for the veterans or Department of Defense personnel will be federal employees, thus resolving this concern.

Finally, with respect to the Secretary's concerns about the $300 million cost, I would like to point out that legislation was introduced during the 107th Congress, H.R. 5042, and again in July of this year, H.R. 116, that would authorize the Department to construct or lease, or through a combination of the two, a major medical facility, or

facilities, at the Fitzsimons site. Specifically, my legislation would authorize $300 million for direct construction, or a combination of direct construction and capital leasing, or $30 million a year for capital leasing alone. This legislation also would give the Secretary of Veterans Affairs the latitude in choosing how to best fund this project. Since the Secretary would have the discretion, he could choose the manner and timing of necessary funding requests. **As such, this authority would prevent funds for this project from being taken from patient care.**

Mr. Chairman, while each of Secretary Principi's concerns are valid, I do not believe they warrant such an impediment as to prevent this project from being realized. And I believe that my legislation as well as the business plan put forward by the University of Colorado Hospital adequately addresses the Secretary's concerns.

This project has another group of potential beneficiaries, as well. As the Committee may be aware, the Department of Defense will likely construct a military treatment facility (MTF) to meet the needs of Buckley Air Force Base. One attractive solution would be to meet the Buckley AFB's MTF requirements by participating in joint construction of a joint Denver Veterans Medical Center and a Department of Defense facility at Fitzsimons. The Air Force, I am pleased to note, has already initiated a study to determine whether joint location and construction is the best option. While that study is not due to be completed until later this month, initial indications are that the AF, as well as the Department of Defense, find this partnership to be in its long term interest.

For this reason, the House-passed Fiscal Year 2004 National Defense Authorization Act (NDAA) included $4 million for the Department of Defense's portion of the design and planning phase of its MTF. Additionally, recognizing the importance of cost savings and other efficiencies, the FY04 NDAA included report language directing that the Department of Defense and the Department of Veterans Affairs to make every effort to share health care facilities. I have included this report language below:

> ***Title XXIV: Departments of Defense and Veterans Affairs Health Care Sharing***
>
> *The committee continues to believe that significant efficiencies are possible if the Department of Defense and the Department of Veterans Affairs (VA) share health care facilities. However, the Department and VA operate only 7 joint ventures, even though the 2 departments operate approximately 240 hospitals. Such incremental progress is representative of the significant bureaucratic challenges facing the health care sharing effort. Nevertheless, the committee believes that the Department and VA should take advantage of health care sharing opportunities whenever possible.*

The committee understands that the Colorado University School of Medicine has begun relocation to the site of the closed Fitzsimons Army Hospital. The Department of Veterans Affairs is currently considering replacement of the Denver VA Medical Center, a 50-year-old structure now co-located with the Colorado medical school, as a part of that relocation. The committee understands that the Department is also considering participation in the VA Medical Center's new facility. As such, the committee believes that the Department of Defense should participate in design and construction of this facility, which would provide ambulatory and acute care medical services to military personnel attached to Buckley Air Force Base. Such an approach would allow the Department to leverage construction, operations, and maintenance costs of a joint facility with VA, and eliminate the Department's need to construct an additional medical treatment facility at Buckley Air Force Base. In this particular case, a joint facility would further benefit by sharing significant assets with the Colorado University School of Medicine Facility, resulting in further savings.

With the expectation that the Department of Defense and the Department of Veterans' Affairs will reach an agreement on sharing design and construction costs at levels representative of their medical requirements, the committee recommends authorization of $4,000,000 for planning and design of a DOD-VA medical treatment facility at the site of the closed Fitzsimons Army Hospital.

The funds included in the House Passed FY04 NDAA were a critical step towards ensuring that the VA and the DOD leverage their resources through joint projects that meet both of their requirements. Constructing a VA-DOD facility at Fitzsimons would serve as a model for future efforts to serve the medical needs of America's service members and veterans alike. And, I would like to point out that inpatient care for the veterans and the DOD will be located in the same federal tower as the veterans ambulatory care, but will be connected to the University of Colorado Hospital to share expensive facilities such as operating rooms and medical imaging.

If the DVMC relocates to Fitzsimons, it could enjoy many of the same opportunities that the UCHSC will enjoy. This would include, but not limited to solving aging facilities issues, capping new facilities cost, enhancing quality of medical care, increasing flexibility and reducing operational costs. Planning studies have shown that a move of the DVMC to the Fitzsimons campus is the most cost effective of the reasonably acceptable alternatives. Clearly the Fitzsimons site is veteran-friendly and the alternative of the DVMC remaining at its current, out-dated facility, without the University next door, is simply unacceptable. Because, as I have already mentioned, some 90 percent of the physicians that work at the VA Medical Center also work at University of Colorado

Health Sciences Center and it would not be in the best interest of high quality patient care to abandon this fifty-year-old partnership.

The close relationship of the VA with the University must be maintained and enhanced. Already, University of Colorado Hospital doctors work in the VA Medical Center and most VA doctors work in the University of Colorado Hospital and have faculty appointments in the Medical School. University physicians in specialty residency programs provide a significant amount of care in the DVMC.

Furthermore, in a medical school environment doctors tend to be better informed of the latest treatment procedures and protocols. They are closer to the "cutting edge" of modern medicine. Quality of medical care for veterans is enhanced in a medical school teaching hospital. Co-locating the UCH with the DVMC will allow University doctors to continue its close relationship in treating veterans.

Currently, the VA uses the University of Colorado Hospital for expensive specialty diagnostics and treatment. As the University completes its move to Fitzsimons, a state of the art medical campus will be developed. Many of the very best services in the United States will be available. For example, the Anschutz Cancer Pavilion, which is already open, is among the best institutions in the nation for all types of cancer treatment and research. The University of Colorado Health Sciences Center is well known throughout the country for its organ transplant programs. Veterans who have highly specialized medical needs must have easy access to the best diagnostic and treatment programs that America provides. Continuing this relationship will contribute to greater cost effectiveness and economies of scale.

There is no question that the move of the DVMC will cost a lot of money. Once again, I would like to point out that the cost of maintaining the current DVMC to satisfy minimal accreditation levels until 2020 has been estimated to be $233 million, and estimates to rebuild the facility in 2020 are $377 million, **in today's dollars**. The estimated cost to relocate the DVMC to Fitzsimons is $300 million. And, the cost to the VA could be as much as ten percent less if the DOD decides to locate the Buckley MTF there as well.

It is my understanding that the VA can only allocate $4 million toward the acquisition of a new or existing medical facility without prior Congressional authorization. Therefore, it will require an act of Congress to appropriate the necessary funding. My legislation, H.R. 116, would give the VA authorization and appropriations to support the relocation and replacement of the DVMC to the UCH Fitzsimons campus.

Mr. Chairman, given the rising demand for veterans health care, and the significant challenges of an aging and increasing less-efficient DVMC facility, my interest and my efforts are aimed at continuing the collaboration between the DVMC, UCHSC and UCH. I believe that the opportunity of locating the DVMC with the UCHSC and the UCH at the Fitzsimons campus will meet the demand for veteran care in the VISN 19 area through 2020 and beyond; provide significant savings in both capital

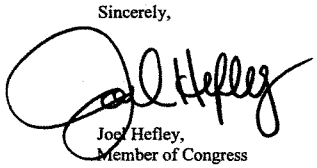
and operational costs for the Department of Veterans Affairs and the taxpayer; continue to meet the DVMC commitment to education and research; and potentially create a national model for the future of veterans' care dealing with both a new concept for facilities and collaboration with long-established partners. However, and more importantly, this move will retain veteran "identity" while also providing optimum patient care.

To date, over 45 local, state and national Veterans' Service Organizations and the American Federation of Government Employees, Local 2241, have expressed their support for this proposal. We stand committed in the goal of providing the up-most modern, comprehensive and cost efficient medical care that we as a nation owe our veterans. And I believe that co-locating the Denver Veterans' Medical Center with the University of Colorado Hospital will achieve these goals.

Mr. Chairman, Congress has a duty to provide the best medical care it can to our nations veterans and we must always strive for the very best health care services it can by utilizing the most cost effective measures available. The fact is, aging facilities, lack of funds, and the growing demand on the veterans health system are proving to be daunting obstacles in meeting Congress' responsibilities to our nation's veterans. However, the possibility for the DVMC to move to Fitzsimons and co-locate with UCHSC and UCH is a unique, one-time opportunity to provide solid and constructive solutions to these challenges. As such, I look forward to working with this Committee in passing H.R. 116 and to bring this project to a positive resolution.

Mr. Chairman, I look forward to the opportunity to provide any additional information to clarify any concerns you, the committee or your staff may have. Again, thank you and the Committee for the opportunity to provide you with this testimony.

Sincerely,



Joel Hefley,
Member of Congress

Enclosures

1) American Legion Letter of Support
2) Resolution of the United Veterans Committee of Colorado
3) AFGE Letter of Support

Department of Colorado
7465 East 1st Ave Ste D
Denver, CO 80230
303.366.5201 - 800.477.1655
e-mail: adjutant@coloradolegion.org

September 27, 2002

Joel Hefley
2230 Rayburn HOB
Washington, DC 20515-0605

Dear Representative Hefley

The American Legion Department of Colorado, by resolution passed by our National organization, representing over 2.8 million members, fully supports the proposed move of the Denver VA Medical Center to the Fitzsimons site.

We began looking at the issue immediately upon the base closure and have been an active participant in all of the discussions and meetings held since that time. Our 27,000 Colorado American Legion members first approved the concept of moving the VA to the Fitzsimons site as early as 1997. We believe that the move is absolutely essential if veterans in the Rocky Mountain region are going to receive the kind of quality health care that they have earned as a result of their service to their country. It would be unacceptable to move the University Medical Center in its entirety and leave veterans behind in an old facility with old equipment. The sharing agreements and cooperation that has existed for so many years between these two entities must continue.

The American Legion has said for several years that it is not "when" but "how" the move will be made. As the old saying goes "the devil is in the details" and we recognize that challenges will be presented in accomplishing the move. We don't believe that anything is insurmountable. It is our understanding that the PVA has expressed some concerns about the treatment that spinal cord injury veterans will receive in any new "shared" facility. We share their concern but we believe that a new facility, with new state of the art equipment and trained specialists in all medical disciplines and world class research facilities can only enhance the services that spinal cord veterans will receive. We believe that establishing a spinal cord injury center is one of the "details" that can be arranged to the benefit of all.

We also believe that the facility can maintain a separate identity. We are on record as advocating for the separate identity and will work with all involved to accomplish this objective. The VA must remain in control of, and be totally responsible, for the care

veterans receive in the new VA Medical Center. All of the specialized programs for veterans must continue, including women veterans, outpatient clinic, spinal cord injury treatment center and medical and surgical acute care units. The Federally employed VA workforce must be permitted the autonomy to carry out their mission under Title 38.

It just makes sense that this arrangement is in the best interest of today's veterans and our future veterans. It is a bold step forward but a step that must be made. We seek your support for this important step.

Sincerely,

Naamon Owens
Department Commander

Cc: Tom Bock, President UVC

UNITED VETERANS COMMITTEE
OF COLORADO
8467 E. COSTILLA AVENUE
ENGLEWOOD, COLORADO 80112

June 5, 2001

RESOLUTION

COLORADO VETERANS SUPPORT FOR THE RELOCATION OF THE VETERANS ADMINISTRATION HOSPITAL FROM 9TH AND CLERMONT TO THE UNIVERSITY OF COLORADO HOSPITAL SITE AT THE FORMER FITZSIMONS ARMY MEDICAL CENTER IN AURORA, COLORADO

WHEREAS, the United Veterans Committee of Colorado is a coalition of 39 Veterans Service Organizations representing the 410,000 veterans in the State of Colorado; and

WHEREAS, the Veterans Administration hospital and the University of Colorado Health Sciences Center and Hospital have been neighbors at 9th and Clermont Street in downtown Denver for more than 50 years; and

WHEREAS, over the years, commercial and residential growth in the area has created severe congestion and gridlock around the hospitals; and

WHEREAS, the two medical facilities have evolved into a partnership type of working relationship by sharing certain medical facilities and equipment to the benefit of both, and many of the doctors and care givers providing the medical services are on the staff of both hospitals; and

WHEREAS, the University Hospital and Health Sciences Center have acquired most of the facilities and land at the former Fitzsimons Army Medical Center, and are in the process of expanding and building a modern state-of-art medical teaching campus preparatory to moving the bulk of their medical treatment facilities from 9th and Clermont to Fitzsimons; and

WHEREAS, the Veterans Administration hospital is 50 years old and sorely in need of restoration or replacement, and the cost of restoration is 30% higher then the cost of replacement and it would still be an old structure; and

WHEREAS, the congestion in the Denver location would still be a factor affecting the convenience and efficient operation of the Veterans Administration hospital; and

WHEREAS, the relocation of the University Hospital to Fitzsimons by itself would create a hardship on the dual staff who would have to travel six miles each way through traffic to meet appointments and provide their medical services at both hospitals; and

WHEREAS, the previously shared facilities and equipment would not be available to the Denver VA Medical Center; and

WHEREAS, the collocation of the Denver VA Medial Center with the University Hospital at Fitzsimons would be less costly then the replacement or restoration of the VA Medical Center at its present location, and would afford considerable savings in operation and personnel costs.

NOW BE IT THEREFORE RESOLVED, that the UNITED VETERANS COMMITTEE OF COLORADO does support and urge the Congress of the United States and the Veterans Administration to approve the relocation of the Denver VA Medical Center from its present location at 1055 Clermont Street, Denver, Colorado to the former Fitzsimons Army Medial Center in Aurora, Colorado.

Submitted by: *Marvin L Meyers*
Marvin L. Meyers
President, United Veterans Committee

Approved and Adopted
by Voice Resolution
United Veterans Committee

June 5, 2001

VETERANS SERVICE ORGANIZATIONS
MEMBERS OF THE UVC

January 1, 2002

Air Force Association
Air Force Sergeant's Association
American Ex-POW's of Colorado
American GI Forum - Colorado State Council
American Legion - Department of Colorado
Association of the United States Army
Avaya Veterans
Colorado Civil Air Patrol
Colorado POW/MIA Coalition
Combat Infantrymens' Association, Colorado
Disabled American Veterans - Department of Colorado
The E9ers Association
Fleet Reserve Association
The Frozen Chosin - Korea
Gold Star Wives of America
Jewish War Veterans
Korean War Veterans
Marine Corps League
Merchant Marines Association
Military Order of the Purple Heart
Military Retirees of Weld County
National Association for Uniformed Services - Colorado State Council
National Guard Association of Colorado
Navy League
Non-Commissioned Officers Association
Paralyzed Veterans of America - Mountain States Chapter
Pearl Harbor Survivors Association, Inc
The Retired Officers Association - Council of Chapters
The Retired Enlisted Association
Society of Military Widows
Special Forces Association
Veterans of Foreign Wars of the US, Department of Colorado
Veterans of World War I, USA
Vietnam Veterans of America - Colorado State Council
Veterans' Widow's International Network
WAVES of Colorado
Women's Army Corps Veterans Association - Mile High Chapter
1st Marine Division
2nd Marine Division
82nd Airborne Division Association, Inc. - Rocky Mountain Chapter
101st Airborne Division

This list of veterans service organizations is not inclusive. Many State and Congressional Representatives, VA facility administrators and staff members for various State and Federal agencies are active by their attendance and participation at the monthly UVC meetings and other UVC functions held throughout the year.

UNITED VETERANS COMMITTEE OF COLORADO
A non-profit coalition of chartered service organizations
representing over 400,000 veterans in Colorado since 1972.

PHONE: 399-8020
EXT. 3155

AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES
Affiliated With the AFL-CIO
LOCAL #2241
1055 Clermont Street
Denver, Colorado 80220

February 10, 2003

Honorable Joel Hefley
6059 South Quebec Street
Suite 103
Englewood, CO 80111

Dear Honorable Hefley:

Thank you for supporting the needs of veterans and civil servants who provide for their care.

As president of AFGE Local 2241 and representative for over 1000 bargaining unit employees at Denver VA Medical Center, Fort Logan National Cemetery, and Health Administration Center (HAC), we support Bill HR 116 introduced by Congressman Hefley on December 12, 2002 and the Capital Asset for Realignment Enhanced Services (CARES), VA's national planning process. Both entities are designed to meet the health care needs of veterans over the next 20 years.

We propose a freestanding facility for our veterans and civil servants caring for those veterans with approximately 795,000 gross square feet of space to accommodate the projected demand for the year 2022.

I know that you understand the crisis facing Coloradans and Americans across the country who have lost their jobs through no fault of their own. Locally, companies such as Lucent Technologies and Qwest offered early retirements to their employees. In many cases, workers were awarded five years to their age and five years to their service, if needed, so that they would meet the company's requirements for retirement. At the same time, the goal of downsizing was accomplished and cost savings realized. The impact to workers was less severe than what it would have been with just a severance package.

For federal employees, retirement age is 50 years with 20 years of service. With the continued downsizing of federal employees, I am asking that you submit a bill to Congress and Senate that will add to age and/or length of service so that the minimum retirement qualifications are met.

I know federal employees would prefer to receive a small pension check the remainder of their lives than a severance package that will only last up to one year.

I hope you will consider recommending a bill so that the downsizing of our federal employees will be easier to accept.

Sincerely,

Everett Johnston
President, AFGE Local 2241

TESTIMONY BY THE HONORABLE SOLOMON P. ORTIZ
REGARDING: HR 2307
BEFORE THE HOUSE VETERANS COMMITTEE
SUBCOMMITTEE ON HEALTH
June 11, 2003

Thank you for the opportunity to talk about an issue that has been a passion for me since my election to Congress 21 years ago: the quality of the services we provide for our veteran population around the nation, but particularly in South Texas.

Each Congress for those 21 years, I have pursued legislation to put a veterans hospital in the South Texas area, which is home to 94,000 veterans of United States wars.

I have worked with the Department of Veterans Affairs for a long time to bring improved services to the long-ignored, veteran population living in the tip of Texas, and the VA has been somewhat responsive with their approach through the CARES program. It is long overdue for the VA to look seriously at the long term needs and service delivery for the all-important population they serve.

CARES data identifies the Rio Grande Valley-Coastal Bend market as one of the most underserved markets in terms of access to inpatient care for the 40,000 veterans residing in South Texas. CARES mandates that inpatient care be available with a 60 minute drive for urban areas and 90 minutes for rural areas. In this market, inpatient care is only available for sick and infirmed veterans in San Antonio, over 2.5 to 6 hours away from South Texas.

The Coastal Bend Valley market was identified as a group of counties containing a number of small to medium sized cities all of which are too remote in terms of travel time and distance to meet CARES access standards for secondary care. There are **presently no inpatient services in this market** other than a limited contract in the Lower Rio Grande Valley and limited access to specialty care. Patients must now travel to San Antonio (2.5 - 6 hrs) for most type of secondary care.

Opportunities to reduce this access gap exist through working with DoD in Corpus Christi as well as the University of Texas Regional Health Academic Center and its affiliated Valley Baptist Medical Center in Harlingen. Two sub-markets were identified: Coastal Bend (Corpus Christi and surrounding area) and Rio Grande Valley (Brownsville, Harlingen and surrounding areas) because transportation between these areas is difficult involving secondary roads which take considerable travel time.

I thank my friend, the co-sponsor of this bill, Dave Hobson, who has been a champion for our veterans and their interests, both in Ohio and in South Texas, and around the nation.

I thank the subcommittee today for moving our bill forward so quickly – as you know, this is an issue that just cannot continue to wait ... we owe our veterans nothing less than state of the art health care that is available near where they live.

STATEMENT OF

CONGRESSWOMAN DEBORAH PRYCE

SUBMITTED TO THE

SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

VA MEDICAL FACILITY CONSTURCTION PROJECTS

WASHINGTON, D.C. JUNE 11, 2003

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

I would like to thank Chairman Simmons, Ranking Member Rodriguez, and the entire Subcommittee on Health for calling this hearing to consider proposed construction projects of Department of Veterans' Affairs medical facilities. Chairman Simmons, I want to applaud you for your continued leadership in providing adequate funding for VA programs. The $63.8 billion funding level set in the compromise budget resolution passed in April represents the highest total funding, the largest increase, and the largest percentage increase ever for the VA budget.

This subcommittee understands the great debt our nation owes to its veterans who selflessly put themselves in harm's way to defend the lives and liberty of others; and that this debt does not end when they leave direct service. It is with this in mind that I address the current void in sufficient healthcare facilities for Central Ohio veterans and their families.

Approximately 250,000 veterans that are served by Ohio's Central Market currently do not have adequate outpatient services and little or no option for local inpatient medical care. Columbus-area residents travel over an hour to Dayton, Chillicothe, and even Cleveland and Cincinnati to receive medical treatment at VA centers. The doctors and nurses at the outpatient clinic in Columbus work hard to offer services for veterans, however, they can not provide the needed outpatient, ambulatory, and specialty care services for which they are not equipped. Additionally, the clinic in Columbus is currently too small and understaffed for even its limited functions. Originally built in 1995, the clinic was designed to handle 135,000 annual visits; it is currently handling over 192,000 visits per year.

To better illustrate this problem, let me call on the story of one of my constituents. Mike Moehl is a 22-year veteran of the Air Force who served in both Vietnam and the Persian Gulf. Over his years in the service, he developed a debilitating ankle injury that forced him to seek treatment. To obtain the needed orthopedic care through the VA system, Mike has

been forced to get up as early as 6 a.m. and organize transportation by bus to Dayton, 75 miles away. The trip costs him a day's wages and adds stress to an already injured ankle. Sadly, Mike is not alone. Many Columbus-area veterans travel as far away as Cleveland for cardiac-specialty care. Last year, approximately 400 people from the Columbus clinic traveled to Chillicothe's VA hospital about 50 miles away. Veterans needing emergency care are first stabilized at a local hospital and then shuttled to VA facilities up to 120 miles away from their loved ones, putting them at an added, unnecessary risk during transportation.

Is it not shocking that Columbus is the nation's 15th largest city, yet it does not possess a full-service VA medical center? A survey of 20 smaller U.S. cities conducted by the *Columbus Dispatch* found that only six are without VA medical centers.

Mr. Chairman, the solution to this problem sits before you today. Through the CARES process, my office has worked hard over the past year, alongside Mr. Tiberi, Mr. Hobson, and the VA Healthcare System of Ohio, to develop a plan that meets the needs of Central Ohio's veterans. The proposed plan includes the construction of 260,000-square-foot new and expanded VA clinic and ambulatory surgical center on the grounds of the federal Defense Supply Center in Columbus. The needed funding for this project is included in the bill introduced by Mr. Hobson, H.R. 2307. The proposed Columbus facility has received the endorsement of the Jewish War Veterans of the U.S.A, the Franklin County Veterans Service Commission, and countless veterans and concerned citizens in my district.

Mr. Chairman, in closing, I want reiterate that the present outpatient clinic in Columbus is simply inadequate to provide the services that our veterans deserve. Furthermore, the CARES Committee has evaluated Ohio's Central Market and agrees that Columbus has a shortage of primary care, outpatient specialty care, and inpatient care services. Without action to correct this wrong, the gap in healthcare service in Central Ohio will continue to widen. It is imperative that our veterans have access to the quality health care they need and deserve.

I want to thank you for the opportunity to bring this issue before you for consideration. I also want to thank you for your bold leadership and look forward to working with you on this issue.

STATEMENT OF
CATHLEEN C. WIBLEMO, DEPUTY DIRECTOR
HEALTH CARE
VETERANS AFFAIRS AND REHABILITATION
THE AMERICAN LEGION
BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
ON
MAJOR MEDICAL CONSTRUCTION LEGISLATION

JUNE 11, 2003

Mr. Chairman and Members of the Subcommittee:

I appreciate the opportunity to present the views of The American Legion regarding the matters of construction and funding to improve, renovate, establish, and update patient care facilities in the Department of Veterans Affairs (VA).

The American Legion understands that many of the health care delivery facilities within VA are aging and in need of improvements. Substantial renovations and improvements relating to fire, safety and modernization as well as reconfiguration to meet the demands of current standards of medical care are needed throughout the entire VA health care system. The increased demands placed on the outpatient and ambulatory care facilities of VA require substantial alterations to meet the changing space requirements. The American Legion believes that no health care system can be expected to deliver quality care in facilities that are deteriorating to states beyond rehabilitation.

With the acceleration of the timeline for completion of the Capital Asset Realignment for Enhanced Services (CARES) initiative for the remaining 20 Veterans Integrated Services Networks (VISNs), VA's Office of Facilities Management has completed assessments on 3150 buildings and over 135 million square feet, in May 2002. These assessments were used by the local facilities as planning tools for determining future space requirements. The bottom line was an estimated $4.5 billion in improvement costs.

VISNs 20, 21, and 22, all submitted VISN level planning initiatives that identified seismic projects in their CARES Market Plans. Many of the buildings are on the Extremely High Risk (EHR) list and do not comply with codes. The VA Southern Oregon Rehabilitation Center in White City, OR was constructed in 1942 and has an inpatient building constructed of unreinforced masonry, which is no longer permissible. Patient privacy, asbestos, and other infrastructure problems are inherent. The estimated price tag to correct these seismic hazards runs into the billions.

The American Legion is disappointed with the inadequacy of the construction funding in recent years as well as the suspension of construction projects during the CARES process. The American Legion is pleased to see, however, that the bills being considered today will help to alleviate the logjam created by this moratorium. It is a welcomed relief.

H.R. 116, The Veterans' New Fitzsimons Healthcare Facilities Act Of 2003

Sec. 2 Authorization of major medical facility projects, former Fitzsimons Army Medical Center, Aurora, Colorado.

This legislation authorizes the Secretary of Veterans Affairs, under 38 U.S.C. 8104, to carry out major medical facility projects at the site of the former Fitzsimons Army Medical Center. Projects selected by the Secretary may include inpatient and outpatient facilities providing acute, sub–acute, primary and long term patient care services. Project costs shall not exceed $300 million, if a combination of direct construction by VA, and capital leasing is selected or no more than $30 million per year, if capital leasing alone is selected.

The American Legion supports the relocation of the Denver Veterans Affairs Medical Center (VAMC) to Fitzsimons. The Fitzsimons Redevelopment Authority has begun converting the site of the former Army medical center to a Bio-Science Park, with the anchor tenant to be the University of Colorado Health Science Center (UCHSC). UCHSC has begun implementing its long-range plan to relocate its existing facilities, including its hospital to Fitzsimons. The Denver VAMC has had a longstanding, synergistic relationship with UCHSC and a move out to Fitzsimons would facilitate sharing, unite the Eastern Colorado Health Care System with the university, and ultimately improve the timeliness and quality of health care provided to the enrolled veterans of the Denver area.

The core space of the current VAMC is 50 years old and undersized for its mission. Its support systems are inadequate for modern health care and it is reaching a non-recovery condition. A state-of-the-art facility would create flexible space and facilitate patient treatment in space designed for modern day health care. The American Legion is pleased to support this legislation.

H.R. 1720, The Veterans Health Care Facilities Capital Improvement Act

Section 2. Authorization of major medical facility projects for patient care improvements.

This legislation offers immediate remedies for VA's critical construction needs with a great deal of flexibility to allow the Secretary to target funding throughout the entire VA health care system. We applaud every effort of Congress to ensure that VA has the necessary means to expedite critical facility improvements, such as renovations and the modernization of heavily impacted VA health care facilities.

The American Legion is concerned that the local interests of the veterans' community may not be reflected in the decision-making process within the Administration, when targeting funds for specific facilities that may be in more need of immediate attention than other facilities. Additionally, The American Legion is concerned with the review process of the project

recommendations. Every effort must be made to ensure the true needs of the stakeholders are taken into consideration before projects are approved. Stakeholder involvement in the CARES project was often overlooked.

Draft Legislation to authorize certain medical facility projects for the Department of Veterans Affairs (VA)

Section 1. Authorization of major medical facility projects.

This legislation authorizes the Veterans Health Administration (VHA) to carry out the following major medical construction projects at the amounts specified:

- Construction of two bed towers to consolidate inpatient sites in inner city Chicago at the West Side Division of the VA Health Care System in an amount not to exceed $98.5 million.

- Construction in Clarke County, Nevada of a specialty facility for a multi-specialty outpatient clinic to replace the leased Las Vegas ambulatory care center and a satellite office for the Veterans Benefits Administration (VBA) in an amount not to exceed $97.3 million.

- Seismic corrections to strengthen Medical Center Building 1 of the VA Health Care System at San Diego, California at a cost not to exceed $48.6 million.

- Renovation of all inpatient care wards at the West Haven, Connecticut, facility of the VA Health Care System in Connecticut to improve the environment of care and enhance safety, privacy and accessibility and to establish a consolidated medical research facility at that location, at a cost not to exceed $50 million.

The American Legion is pleased to see all four of these projects receiving priority. Each of these areas accurately represents the current condition of the VA health care system. Such inadequate facilities as these are overburdened and unable to meet the growing demand for health care.

The American Legion National Commander, Ron Conley, has visited over fifty VA medical facilities this year. At each facility, he learns first-hand of the challenges VA administrators must overcome in order to provide timely access to quality health care faced with limited resources and inadequate facilities. During his visit to the Lakeside VAMC, Commander Conley learned of the problems that patients, seeking care in Chicago, will now encounter. The CARES process has driven significant health care out of the city of Chicago and many veterans who depended on Lakeside for their primary care are left seeking other alternatives.

Additionally, the reduced tertiary care capability at Lakeside threatens future affiliation with Northwestern University. The downsizing of services provided at Lakeside has strained the Northwestern University/VA affiliation to the limit. Lakeside's affiliation with Northwestern University not only helps the students of Northwestern, but also saves VA millions of dollars each year in health care delivery costs and provides a large pool of potential VA health care providers.

The American Legion believes that the construction of the two bed towers to consolidate inpatient care in the Chicago area should be completed, as quickly as possible. The veterans in the area have endured nearly three years of what is best described as a 'roller coaster ride' regarding the fate of veterans' health care delivery in the area. The CARES pilot program was fraught with uncertainty and displeasure concerning the process and some of the outcomes. The veterans dependent upon the Lakeside VAMC for their health care needs are the casualties of that process.

Las Vegas is one of the fastest "fast-growing" cities in the country and the Las Vegas veterans' population is growing, as well. Commander Conley visited the Las Vegas Ambulatory Care Center in November 2002. During his visit, he learned of the numerous problems with the steel used in the construction of the building and the inadequate floor supports, as well. This two-story facility, built in 1996 has been plagued with problems. The surgery room has never been used due to improper and unsafe air pressure in the room. The Commander was told that at night, employees fill the drains of the sinks with disinfectant because sewer gasses back up into the sinks and cause employees to become ill.

With the unbelievable problems VA experienced with the "new clinic," that could not be used due to structural safety issues being noted just after it was built, the multi-specialty clinic proposed is long over due. The American Legion cautions that, given what happened with the first unusable clinic, VA would do well to scrutinize and oversee the construction of this new building to ensure its soundness.

The seismic corrections proposed at the VA San Diego Health Care System date back to February 1997. Design deficiencies were noted and corrections developed, but not implemented. The American Legion believes this is a critical issue and would like to see more of the seismic corrections identified system-wide receive the funding needed to ensure VA facilities are protected from seismic occurrences. Patient safety should be the first and foremost concern. It would be a tragedy to have one of these buildings collapse as a result of Congress' tight purse strings.

The VA Connecticut Health Care System West Haven Campus is in dire need of the proposed improvements. The West Haven Campus is just one part of the Connecticut VA, which also includes the Newington Campus and six Community Based Outpatient Clinics (CBOCs). With more than 330,000 veterans in Connecticut and the southern New England area, the need for adequate inpatient care wards at West Haven is paramount.

Commander Conley noted in the facility report of his visit to West Haven that the funding dollars are not meeting the current demand for care. In 1998, West Haven served 35,000 veteran patients. In 2002, they served 50,000. The average waiting time for a primary care appointment at West Haven is 90 days and as of April the number of veterans waiting 90 days is 184.

The outdated, inefficient layout of the current patient care space needs the attention and funds proposed in this bill to ensure veterans are getting the best of care in the most conducive environment. The American Legion applauds Ranking Democratic Member Lane Evans (IL) for introducing this important legislation.

Section 3. Authorization of a major medical facility lease.

The VA may enter into a lease for a major medical facility in Charlotte, North Carolina in an amount not to exceed $3 million.

Access for primary care in the Charlotte area must be improved. In the VISN Market Plan, it was stated that a Specialty Outpatient Clinic (SOPC) is planned for Charlotte, NC. Along with six new proposed CBOCs for the Southwest Market, demand on Specialty Care, Mental Health and Primary Care should be relieved. The American Legion notes the proposed placement of CBOCs to meet the CARES access standard of 70 percent throughout all of the VISN Market Plans.

Section 4. Limitation on disposal of Lakeside Division, Department of Veterans Affairs medical facilities, Chicago, Illinois.

No funds available to VA may be used for disposal of the Lakeside Division facility of VA's medical facilities in Chicago, Illinois until VA has entered into a new contract to construct a new bed tower at the West Side VAMC in Chicago. The term disposal includes entering into a long-term lease or sharing agreement under which a party other than VA has control of the property.

It would be an injustice to dispose of the Lakeside facility before a contract authorizing the construction of the new bed tower is in place. The American Legion believes the construction should be completed and the new facility actively treating patients before any changes take place at the Lakeside facility.

H.R. 2307, to provide for the establishment of new Department of Veterans Affairs medical facilities for veterans in the area of Columbus, Ohio, and in south Texas.

Section 1. New Department of Veterans Affairs Medical Facility, Columbus, Ohio.

The Market Plans submitted by VISN 10 through the CARES process proposes to contract out in the community for beds to raise the access standards for hospital care from 39 percent to 83 percent by Fiscal Year 2012. It is clear that something needs to be done with the lack of care in the Columbus area and the increased demand through at least 2012. The American Legion does not agree with always contracting out for care in order to meet demand. The possibility of building a new facility in the Columbus area should be revisited by the CARES team and flushed out keeping in mind the needs of the veteran.

Section 2. New Department of Veterans Affairs Medical Facility, South Texas.

Again, The American Legion recognizes the fact that VA is going through an enormous and complicated process to target those areas and facilities where veterans reside and get their care. The South Texas market in VISN 17 has identified the need for expanded service and space in order to meet the demands for veteran care in the future.

The American Legion believes this bill is a step in the right direction and we support it in so far as there has been some recognition of the lack of access, as well as the increased need in the South Texas and Columbus areas.

Conclusion

The American Legion continues to advocate for adequate VA construction appropriations. The quality of VA medical facilities directly affects VA's ability to provide timely access to quality health care. The American Legion's recommendations for VA construction funding are based on sound, realistic assessments of system-wide needs.

CARES is being relied upon as a panacea for the ills within the physical structure of the VA health care system. The American Legion is concerned that too much reliance is being placed on this comprehensive initiative to fulfill the structural needs of VA rather than fixing apparent and immediate needs of critical VA care facilities. While CARES seeks to improve the overall future physical VA health care system, VA is delaying the urgent repairs and renovations necessary to many of the currently used facilities that are being relied upon by veterans.

The legislation before us today is a solid step in the right direction to address the immediate construction needs of the VA's health care facilities. Congress must make every effort to continue to fund and authorize the necessary projects to improve the overall VA health care system.

Mr. Chairman, we applaud you and the Members of this distinguished Subcommittee for the work that you have done and continue to do for the Nation's veterans and their families. The American Legion looks forward to working with you and the Members of this Subcommittee to improve the lives of America's veterans and their families.

The American Legion
For God and Country

★ WASHINGTON OFFICE ★ 1608 'K' STREET, N.W. ★ WASHINGTON, D.C. 20006-2847 ★
(202) 861-2700 ★ FAX (202) 861-2728 ★

June 11, 2003

Honorable Rob Simmons, Chairman
Committee on Veterans' Affairs
Subcommittee on Health
338 Cannon House Office Building
Washington, DC 20515

Dear Chairman Simmons:

The American Legion has not received any federal grants or contracts, during this year or in the last two years, from any agency or program relevant to the subject of the June 11 hearing concerning Major Medical Construction Legislation.

Sincerely,

Cathleen C. Wiblemo, Deputy Director Healthcare
National Veterans Affairs and
Rehabilitation Commission

SERVING
WITH
PRIDE

TESTIMONY

of

Richard "Rick" Jones
AMVETS National Legislative Director

before the

Committee on Veterans' Affairs
Subcommittee on Health
U.S. House of Representatives

on

1.) **H.R. 1720, the Veterans Health Care Facilities Capital Improvement Act; a draft bill by Ranking Member Evans to authorize specific major medical construction projects; and**

2.) **H.R. 116, a bill to authorize relocation of the Denver VA Medical Center**

Wednesday, June 11, 2003
2:00 PM, Room 334
Cannon House Office Building

A M V E T S

NATIONAL
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Chairman Simmons, Ranking Member Rodriguez, and Members of the Subcommittee:

On behalf of National Commander W.G. "Bill" Kilgore and the nationwide membership of AMVETS (American Veterans), I thank you for the opportunity to present testimony to the Subcommittee on H.R. 1720, the Veterans Health Care Facilities Capital Improvement Act; a draft bill by Ranking Member Evans to authorize major medical construction projects in Las Vegas, Chicago Westside, West Haven, San Diego, and a lease at the Charlotte, NC out patient clinic; H.R. 116, a bill to authorize relocation of the Denver VA Medical Center to the old Fitzsimmons Army Hospital site; and other issues critical to the improvement of patient care facilities within the VA system.

Mr. Chairman, AMVETS has been a leader since 1944 in helping to preserve the freedoms secured by America's Armed Forces. Today, our organization, composed of a large number of Vietnam veterans, continues its proud tradition, providing, not only support for veterans and the active military in procuring their earned entitlements, but also an array of community services that enhance the quality of life for this nation's citizens.

AMVETS strongly supports the legislation subject to this hearing. As the Subcommittee is aware, AMVETS is a partner in producing *The Independent Budget*. For the 2004 Fiscal Year, *The Independent Budget* recommends appropriations of $436 million to meet the major construction needs of the VA. Currently, many VA medical center facilities, with an average age of over 50 years, are in critical need of repair. Improvements to these facilities will eventually pay for themselves through future savings as the entirety of VA facilities are modernized. AMVETS believes the facility improvements that would be authorized by the legislation under discussion are essential to meet these obligations.

Beginning with Fiscal Year 1994, the VA's construction appropriation for major and minor projects began a sharp decline to their current low levels. This decline, along with ongoing reconfiguration of the VA healthcare system through Capital Assets

Realignment for Enhanced Services (CARES) has prevented the VA from meeting its obligation to protect its current assets by funding needed construction, maintenance, and renovation, whether these assets are to be used in their current capacity or realigned to enhance services. The CARES process continues to be used as an excuse by appropriators for foot-dragging on most of the construction projects authorized by this Subcommittee and needed by our veterans.

This approach is shortsighted and forces the VA to endure major unmet needs throughout the system. The condition of our VA facilities is not only an infrastructure problem, but a patient and staff problem as well. Our veterans have earned their health benefits through their service. When veterans use a VA facility, they must be assured that the facilities available to them have the equipment needed to provide adequate care and their time there is made as comfortable as possible. The professionals that staff our VA facilities must also be provided facilities that offer them a safe, well-equipped workplace.

AMVETS has been supportive of the CARES process. However, we believe the efforts of the CARES process must remain separate from the urgent needs of the VA infrastructure and facilities. CARES is for tomorrow, but these facilities, and the staff and patients they house, need help today.

As noted in this year's edition of *The Independent Budget*, AMVETS recognizes that the location and missions of some VA facilities may need to change to improve veterans' access and allow more resources to be devoted to medical care. These changes are understandable to keep the VA system efficient and to provide the most state-of-the-art care possible. These concerns for the future notwithstanding, the steady decline in appropriations for VA construction has forced the VA to delay current, high priority projects, such as ambulatory care improvements, seismic corrections, and other renovations to meet basic safety standards.

With these concerns in mind, AMVETS is encouraged to see that H.R. 1720 would authorize appropriations of $500 million for major VA construction for Fiscal Year 2004, and further increase that level by an additional $100 million for Fiscal Years 2005 and 2006 respectively. While AMVETS applauds the Chairman's bill for including this funding, we further encourage the Subcommittee to address the needs of VA minor construction accounts. *The Independent Budget* for Fiscal Year 2004 recommends $490 million for these minor construction needs and also recommends increasing the limit for individual minor construction projects from $4 million to $10 million. By increasing this cap, it would enable the VA to plan improvements in an adequate and efficient manner.

Mr. Chairman, AMVETS applauds the Subcommittee's efforts to provide the needed resources to allow the VA to maintain and modernize the over 2000 buildings in its healthcare system. Thank you again for the opportunity to present testimony to your panel on these issues of critical importance to all veterans. We sincerely appreciate your vigilance in efforts to improve veterans earned healthcare benefits and services.

SERVING
WITH
PRIDE

June 11, 2003

The Honorable Rob Simmons, Chairman
House Veterans' Affairs Committee
Subcommittee on Health
Cannon House Office Building
Washington, D.C. 20515

Dear Chairman Simmons:

Neither AMVETS nor I have received any federal grants or contracts, during this year or in the last two years, from any agency or program relevant to the June 11, 2003, Subcommittee hearing on major medical construction projects.

Sincerely,

Richard Jones
National Legislative Director

AMVETS

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STATEMENT OF
ADRIAN M. ATIZADO
ASSOCIATE NATIONAL LEGISLATIVE DIRECTOR
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH
UNITED STATES HOUSE OF REPRESENTATIVES
JUNE 11, 2003

Mr. Chairman and Members of the Subcommittee:

On behalf of more than one million members of the Disabled American Veterans (DAV) and its Auxiliary, we are pleased to express our views on the four pieces of legislation before the Subcommittee.

Since its founding more than 80 years ago, the DAV has been dedicated to a single purpose: building better lives for America's disabled veterans and their families. Preservation of the integrity of the Department of Veterans Affairs (VA) health care system is of the utmost importance to the DAV and our members.

One of VA's primary missions is the provision of health care to our nation's sick and disabled veterans. The Veterans Health Administration (VHA) is the nation's largest direct provider of health care services with 4,800 significant buildings. This year, VHA projects it will provide health care services to over four million veterans. The quality of VA care is equivalent to, or better than, care in any private or public health care system. VA provides specialized health care services—blind rehabilitation, spinal cord injury care, Posttraumatic Stress Disorder treatment, and prosthetic services—that are unmatched. VHA has been cited as the nation's leader in tracking and minimizing medical errors.

The agenda for today's hearing includes H.R. 1720, the Veterans Health Care Facilities Capital Improvement Act; H.R. 116, the Veterans' New Fitzsimons Health Care Facilities Act of 2003; H.R. 2349, to authorize certain major medical facility projects for the VA; and H.R. 2307, to provide for the establishment of new VA medical facilities for veterans in the area of Columbus, Ohio, and in south Texas. DAV is especially concerned about maintaining a modern, effective, and safe system to meet the unique health care needs of our nation's veterans, which these bills address.

All four measures seek to improve VA's infrastructure when for more than a decade, VA has not been provided adequate appropriated funds for its major and minor construction projects. Equally important, these bills recognize the current state of VA's health care facilities nationwide, which have fallen into decay through the ravages of time and the obsolescence that comes so quickly when health care facilities are not regularly upgraded. The DAV has no resolution concerning these bills. However, because these issues have been addressed in *The Independent Budget*, we have no objection to them.

H.R. 1720

This measure authorizes the Secretary of Veterans Affairs to carry out construction projects costing not more than $100 million in FY 2004, $125 million in FY 2005, and $150 million in FY 2006 at locations of his choice. With authorization for $500 million in FY 2002, $600 million in FY 2003, and $700 million in FY 2006, the purpose of such projects are to improve seismic protection related to patient safety, fire safety, utility systems and ancillary patient care facilities, accommodation for persons with disabilities, and patient care facilities to specialized programs of the VA.

The approval of individual facility projects by the Secretary of Veterans Affairs will be based on recommendations of an independent capital investments board. In addition, the Secretary must report his actions to Congress. The bill would also mandate a review of this delegated-project approach by the General Accounting Office, to ensure this is an effective mechanism to advance some VA medical construction during and after the Capital Assets Realignment for Enhanced Services (CARES) process.

The problems addressed by H.R. 1720 are those we have specifically called attention to in the IB. Enactment of this bill would give the Secretary an opportunity to identify, consider, approve, and develop construction projects appropriately, with the authority and funds to do so. Many VA facilities need funds right now, on an emergency basis, for major construction and repair projects; other facilities have more chronic needs for restoration and capital improvements that have lingered unfunded for years.

In the June 1998 Price Waterhouse study, more than 42 percent of all VHA facilities were found to be at least 50 years old. Moreover, the report revealed VA invests less than 2 percent of the plant replacement value for its entire facility infrastructure when a minimum of 5 to 8 percent investment is necessary to maintain a healthy infrastructure. According to outside experts, such indicators paint a clear and disturbing picture. If construction funding continues to be inadequate, it will become increasingly difficult for VA to provide high quality services in old, inefficient, and unsafe patient care settings.

Notably, the CARES process is a major contributing factor to VA's diminutive annual budget for major medical construction projects. This nationwide initiative was implemented to realign and enhance VA health care infrastructure to effectively and efficiently meet the future needs of veterans. Deferrals of funds for needed construction projects were intended to permit CARES to proceed in an orderly way, avoiding unnecessary spending on health care facilities that might not be needed by veterans in the future.

Thus, while H.R. 1720 ensures an effective mechanism to advance some VA medical construction during and after the CARES process and its recommended $1.8 billion appropriation for three years, the IB recommends for FY 2003 alone that Congress appropriate $436 million for major construction, which includes $285 million to correct seismic deficiencies, and $490 million for minor construction. More must be done through the regular appropriations process in the annual budget for VA construction.

H.R. 116

Under this bill, the Secretary of Veterans Affairs is authorized to carry out major medical facility projects at the site of the former Fitzsimons Army Medical Center, Aurora, Colorado, and may include inpatient and outpatient facilities to provide acute, sub-acute, primary, and long-term care services. Using funds appropriated for FY 2004 through 2006 costing no more than $300 million for direct construction, capital leasing, or a combination of both, and $30 million for each fiscal year for capital leasing alone, the bill would also require the Secretary at the end of the process to report his actions to Congress.

Clearly there are many options to consider when implementing a major medical facility project as proposed in H.R. 116. In this instance and as with all VA medical affiliations, we believe VA should maintain a strong presence by keeping a separate identity with direct line authority in all areas involving care of veteran patients. This will allow VA to fulfill its primary health care mission to serve the needs of America's veterans by providing primary care, specialized care, and related medical and social support services.

DAV recognizes the importance of maintaining relationships with medical affiliates. Just as academic medical centers are under increasing financial pressures to reduce healthcare professional training, VA has mitigated this gap with training programs for VA and the nation. Last year, VHA's academic affiliates trained more then 85,000 clinicians. In addition to their value in developing the nation's health-care workforce, the affiliations bring first-rate health-care providers to the service of America's veterans.

The opportunity to teach attracts the best practitioners from academic medicine along with state-of-the-art medical science to VA. Veterans get excellent care, society gets doctors and nurses, and the taxpayer pays a fraction of the market value for the expertise the academic affiliates bring to VA. If enacted, H.R. 116 would allow construction of a freestanding self-contained medical facility, with sharing and coordination of certain support services. We would, however, have serious concerns with an integrated inpatient facility with joint governance and management.

H.R. 2349

This bill authorizes the Secretary of Veterans Affairs to carry out major medical facility projects and lease with specified amounts. Such projects include: new construction at the West Side VA Medical Center, Chicago, Illinois, not to exceed $98.5 million; new construction at Clark County, Nevada, not to exceed $97.3 million; seismic corrections to Medical Center Building 1, San Diego, California, not to exceed $48.6 million; renovation for all inpatient care wards and consolidation of medical research facility at West Haven, Connecticut, not to exceed $50 million; and lease for an outpatient clinic in Charlotte, North Carolina, not to exceed $3 million.

This bill would also restrict the use of any construction funds to dispose of Lake Side VA Medical Center, Chicago, Illinois, until such time as the Secretary of Veterans Affairs has entered into a construction contract at West Side VA Medical Center, Chicago, Illinois.

H.R. 2349 also provides for seismic corrections of Medical Center Building 1 of the San Diego VA Medical Center. This building is classified as "exceptionally high risk" (EHR) and such corrections would mitigate life safety hazards and allow for continued operation after a seismic event. In addition to patient and employee safety, seismic safety continues to be a major concern when 890 of VA's 5,300 buildings have been deemed at "significant" seismic risk and 73 VHA buildings are at EHR of catastrophic collapse or major damage. Indeed, these data leave no doubt that immediate remedial action is the only prudent course.

The bill would provide for new construction projects for a multi-specialty outpatient clinic Las Vegas, Nevada, and a bed tower to be consolidated with West Side VA Medical Center in Chicago, Illinois. Such projects would accommodate the loss of a VA medical facility in both areas and continue to provide a full continuum of high quality medical care.

H.R. 2307

Enactment of this measure would provide for major medical construction projects on available Federal land at the Defense Supply Center, Columbus, Ohio, with authorization of $90 million, and in South Texas with amounts appropriated for the construction of the medical facility not exceeding the amount equal to the product of the number of patient beds to be provided in the facility, and $290,000.

The DAV, along with the IB veterans service organizations, supports the CARES process; however, construction deferrals have resulted in adverse effects on health care quality and capacity, as well as the loss of capital asset value, and the overall inefficiency of delay. Such inaction does more than leave in place the unsatisfactory status quo; it is counterproductive inasmuch as it compounds existing problems and erodes the very foundation of the VA health care system. We look forward to working with the members of this Committee to obtain the funding necessary to restore and maintain a viable, modern, world-class health care system.

In closing, DAV sincerely appreciates the Subcommittee for holding this hearing and for its interest in improving benefits and services for our Nation's veterans. The DAV deeply values the advocacy this Subcommittee has always demonstrated on behalf of America's service-connected disabled veterans and their families. Thank you for the opportunity to present our views on these important measures.

DISABLED AMERICAN VETERANS

Building Better Lives for America's Disabled Veterans

DISCLOSURE OF FEDERAL GRANTS OR CONTRACTS

The Disabled American Veterans (DAV) does not currently receive any money from any federal grant or contract.

During fiscal year (FY) 1995, DAV received $55,252.56 from Court of Veterans Appeals appropriated funds provided to the Legal Service Corporation for services provided by DAV to the Veterans Consortium Pro Bono Program. In FY 1996, DAV received $8,448.12 for services provided to the Consortium. Since June 1996, DAV has provided its services to the Consortium at no cost to the Consortium.

National Service and Legislative Headquarters • 807 Maine Avenue, S.W. • Washington, D.C. 20024-2410 • Phone (202) 554-3501 • Fax (202) 554-3581

STATEMENT OF

CARL BLAKE, ASSOCIATE LEGISLATIVE DIRECTOR

PARALYZED VETERANS OF AMERICA

BEFORE THE

HOUSE COMMITTEE ON VETERANS' AFFAIRS

SUBCOMMITTEE ON HEALTH

CONCERNING

H.R. 1720

H.R. 116

H.R. 2349

H.R. 2307

JUNE 11, 2003

Chairman Simmons, Ranking Member Rodriguez, members of the Subcommittee, PVA would like to thank you for the opportunity to testify concerning H.R. 1720, the "Veterans Health Care Facilities Capital Improvement Act"; H.R. 116, the "Veterans' New Fitzsimmons Health Care Facilities Act of 2003"; and H.R. 2349, a bill to authorize certain major medical facility projects for the Department of Veterans Affairs; and H.R. 2307, a bill to provide for the establishment of new Department of Veterans Affairs medical facilities for veterans in the area of Columbus, Ohio, and in south Texas.

PVA strongly supports H.R. 1720, the "Veterans Health Care Facilities Capital Improvement Act," introduced by Chairman Simmons. PVA has been a leading advocate for similar measures in the past because the Department of Veterans Affairs (VA) is indeed facing a crisis. *The Independent Budget* states:

> [W]e have continually called for increased construction budgets to address the deterioration of VA buildings. Our recommendations have not been implemented. Now VA, and particularly VHA [Veterans Health Administration], embark on a period of realignment and restructuring through the CARES [Capital Assets Realignment for Enhanced Services] process with an infrastructure that has not been properly maintained. The backlog of vital maintenance and renovation has steadily grown while construction budgets continue to steadily decline. The poor condition of many VA properties limits the options available for constructive

> realignment and devalues assets that might otherwise be converted to more effective uses.

Last Congress, PVA enthusiastically supported a similar measure, and many of our concerns remain the same. We testified that:

> A study conducted by Price-Waterhouse in 1998 recommended that in order for the VA to protect its facility assets against deterioration and to maintain an adequate and appropriate level of building services, 2 to 4 percent of the assets' replacement value should be spent each year for facility improvements, and another 2 to 4 percent should be expended for nonrecurring maintenance. The VA's total facility assets are valued at approximately $35 billion. Hence, according to the study, the VA should be spending $700 million to $1.4 billion annually, as well as a similar amount for nonrecurring maintenance.

We also noted that "the physical infrastructure of the VA is indeed facing an emergency. With further inaction, a valuable and irreplaceable national asset will be lost, for without health care buildings you do not have a health care system."

This year, *The Independent Budget* called for a major construction appropriation of $436 million, as well as $400 million for CARES related planning and design initiatives. We are pleased that H.R. 1720 authorizes $500 million in FY 2004 for the major construction projects identified in section 2 of this legislation.

PVA also applauds the Subcommittee for its explicit recognition of the importance of spinal cord injury centers and specialized services programs within the scope of the "Veterans Health Care Facilities Capital Improvement Act." We are also pleased to see that "improved accommodation for persons with disabilities, including barrier-free access" is a goal of this bill.

We are interested in evaluating the effect of providing general authorization authority as compared to specific authorization authority. As we stated in testimony last Congress concerning this concept:

> As part of PVA's interest in finding ways to streamline and make more responsive the VA's construction program, we are interested in evaluating the effect of providing general authorization authority as compared to the specific authorization authority required by 38 U.S.C. § 8104(a)(2). One pitfall to the current arrangement is the "feast or famine" effect inherent in the current inadequate funding levels. Because of the funding logjam, the process may take upwards of ten years from initial planning to actual construction. The individual Veterans Integrated Service Networks (VISNs) are wary of adjusting their

> projects because doing so would jeopardize their place in the "queue." Projects authorized, and finally funded, may no longer meet the original needs for which the project was authorized. Under-funding the construction budget also results in larger, more expensive, and less flexible projects. Since there is no confidence that future construction budgets will be forthcoming every project is made as comprehensive as possible. This is certainly an illustration of being penny wise and dollar foolish.

Finally, PVA wants to state unequivocally that these much needed construction funds must not come at the expense of, or out of, the medical care budget line-item that provides direct health care services to veterans. The VA medical system is facing a crisis, a crisis brought about by inadequate funding, a crisis that has lead to health care rationing and shocking waiting times faced by veterans all across this nation. The solution to this crisis lies in providing the funding required by VA health care in the medical care account. The crisis facing VA infrastructure, likewise, will be solved by providing the necessary additional resources in the construction line-item.

PVA has concerns regarding H.R. 116, the "Veterans' New Fitzsimmons Health Care Facilities Act of 2003." PVA stands committed to finding workable solutions for the delivery of veterans' health care in the Denver area, and we have worked tirelessly toward this end.

PVA understands that constructing a new, freestanding VA medical center at the Fitzsimmons site is no longer feasible due to space limitations at the site and cost concerns. We are adamantly opposed to any option that would essentially integrate Denver VA medical center patients into the patient population of the University of Colorado Hospital. We are open to the many collaborative opportunities between the two entities, but integrating veteran patients in this manner would fundamentally change the way VA provides care.

We believe that an option involving the VA leasing within a new facility could be a viable one, as long as many essential elements are included within such a plan. These elements would include governance issues ensuring that VA leadership has direct line authority and accountability for veterans' health care, ensuring dedicated space and a distinct VA presence, ensuring that facility staff remain federal (VA) medical center

employees, and finally, ensuring that current VA procedures and policies for the provision of appropriate pharmaceuticals, supplies and prosthetics be maintained. We believe that these issues must be resolved before blanket authority is provided to proceed.

We also believe that a new spinal cord injury center is needed in the Denver area, and that this center should move forward along with any decisions concerning Fitzsimmons. Any new SCI center must be operated as all current centers are, with dedicated services and staff. The development of a new SCI center must follow the requirements of the Memorandum of Understanding between VA and PVA allowing for architectural review, must operate in compliance with all existing VA policies and procedures, and must continue the relationship between VA and PVA allowing for site visits of SCI center facilities.

PVA stands ready to work with this Subcommittee to ensure that veterans in Colorado are accorded the very best VA health care.

Finally, PVA supports H.R. 2349. One of our gravest concerns over the CARES process was that this initiative would be used as an excuse to shutter VA facilities, rather than to enhance the health care provided to veterans and move the VA health care system into the 21st century. We have increasing concerns as the CARES process unfolds that it will be easier for CARES planners to close facilities than it will be for them to actually produce the resources to make needed enhancements at other facilities at the same time. For this reason, we applaud the provision in H.R. 2349 which prohibits the disposal of the Lakeside Division medical facility in Chicago, Illinois before the VA has entered into a contract to construct a new bed tower at the West Side medical center. Likewise, we support construction or facility authorization measures such as H.R. 2307 if these measures address demonstrated needs. We have consistently stressed that necessary construction must proceed, that we can not sit around watching facilities deteriorate and needed new construction not be carried out solely because we are waiting for a process that will be completed sometime in the future. Veterans still seek health care, and these

services must be provided.

Likewise, *The Independent Budget* has stressed the importance of preserving VA's historic structures, and the fact that the CARES process is ill-equipped to address this vital concern:

> VA's historic structures provide direct evidence of America's proud heritage of veterans' care and enhance our understanding of the lives and sacrifices of the soldiers and sailors that fashioned our country. VA owns almost 2,000 historic structures that must be preserved and protected. The first step in addressing this important responsibility is for VA to develop a comprehensive national program on historic properties. Since the majority of these structures are not suitable for modern patient care, the current CARES process will not result in a national program for historic preservation. Therefore, a separate initiative must be undertaken immediately.

The Independent Budget calls for the development of a comprehensive national program on historic properties and the provision of adequate funding for this important preservation work.

In closing, the final outcome, and the effective results of the CARES process remains to be determined in the future. But this is no excuse to not provide vital construction and maintenance dollars, nor should it serve as an excuse to close hospitals without providing the "enhanced services" that are a key component of the CARES acronym. The VA's construction responsibilities run the gamut from planning necessary enhancements, renovations, and new facilities to ensuring that existing spaces are put to optimal uses and historic properties, and the heritage they represent, are preserved and utilized.

Thank you for the opportunity to testify today. I would be happy to answer any questions that you might have.

Information Required by Rule XI 2(g)(4) of the House of Representatives

Pursuant to Rule XI 2(g)(4) of the House of Representatives, the following information is provided regarding federal grants and contracts.

Fiscal Year 2003

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation — National Veterans Legal Services Program— $220,000 (estimated).

Fiscal Year 2002

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation — National Veterans Legal Services Program— $179,000.

Fiscal Year 2001

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation — National Veterans Legal Services Program— $242,000.

STATEMENT OF

PAUL A. HAYDEN, DEPUTY DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

H.R. 1720 -- VETERANS HEALTH CARE FCILITIES CAPITAL IMPROVEMENT ACT,
H.R. 116 -- RELOCATING DENVER VA MEDICAL CENTER,
H.R. 2307 -- ESTABLISHING A NEW VA MEDICAL FACILITY, AND
H.R. 2349 -- MAJOR MEDICAL FACILITY PROJECTS FOR VA

WASHINGTON, DC JUNE 11, 2003

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the 2.6 million men and women of the Veterans of Foreign Wars of the United States (VFW) and our Ladies Auxiliary, I would like to extend our appreciation for being included in today's important hearing on these bills related to construction within the Department of Veterans Affairs (VA). While we, as well as this subcommittee, appropriately focus the majority of our attention on medical care, it is essential that we also place an emphasis on VA's decaying physical assets.

VA has one of the largest building inventories in the federal government: over 5,000 buildings, including 163 medical centers and over 850 outpatient clinics. Not only does the sheer size of the system create difficulties, age does too. Although many new facilities have been built in recent years, the average age of VA buildings is over 50 years old and growing older each day.

It is essential for VA to build, renovate, and maintain healthcare facilities that are able to provide quality healthcare without sacrificing patient and worker safety and convenience so VA can continue to take care of our nation's veterans long into the future.

This construction process, however, is currently broken. We feel that the Capital Assets Realignment for Enhanced Services (CARES) process is being used as an excuse to not do any major construction, all while the aged VA infrastructure deteriorates daily. There are a large number of urgent projects that must be addressed, including those that affect patient and worker safety, such as the over 70 buildings in "exceptionally high risk" of catastrophic collapse because VA is not making necessary seismic improvements. While we appreciate and support the idea of

CARES, we strongly believe that this cannot preclude VA from construction, especially at high-risk buildings.

H.R. 1720, Veterans Health Care Facilities Capital Improvement Act

The VFW is pleased to strongly support the *Veterans Health Care Facilities Capital Improvement Act*. This legislation would authorize the Secretary to carry out certain major construction projects to improve, renovate, or update VA facilities without requiring Congress' specific authorization for individual projects. Further, for these projects, the legislation authorizes the appropriation of $500 million in fiscal year (FY) 2004, $600 million in FY 2005, and $700 million in FY 2006.

We feel this legislation would be a great benefit to veterans, as it would significantly enhance VA's ability to carry out major construction projects. First, it would improve VA's ability to respond to its immediate needs without having to wait for a new appropriations cycle.

Second, it would provide VA with greater flexibility in choosing projects, resulting in timelier repair of urgent priorities, such as the aforementioned seismic improvements.

Third, the legislation would offer the incentive for more manageable projects that are targeted to address veterans' needs, including improved access for the disabled, safety improvements, or access to care. This could, for example, include renovating or adding patient beds, or expanding specialty program capabilities. We believe that a smaller, incremental approach would also lead to more effective use of resources as VA could continuously adjust the plans for any changes in constituency or technology.

We also fully support the increased appropriations recommendations contained in the bill. They acknowledge the current crisis in which VA finds itself. Despite recent increases, the amount of money appropriated for major construction is significantly lower than it was even ten years ago. As a result, VA is not currently able to maintain and enhance those aging buildings under its control. Over time, patient and worker safety and access will continue to grow as a problem. We are nearing the tipping point and this legislation would help avert the crisis. We feel that the recommended $500 million appropriation would greatly enhance VA's ability to meet the challenges that their current physical assets present.

This legislation is similar to legislation we supported and that passed the House in the 107th Congress, H.R. 811. Unfortunately, the Senate did not approve similar legislation and the

Appropriations Committees did not include the funding increases either. We would hope that these committees would favorably consider this legislation, and we will continue to urge them to do so.

H.R. 116, A bill to authorize relocation of the Denver VA Medical Center

The VFW is generally supportive of this legislation that would give the Secretary of VA the authority to enter into a lease or a construction agreement for a new VA medical facility at the former Fitzsimons Army Medical Center in Aurora, Colorado.

Although we support this legislation, as it would result in a new medical facility for veterans, we do have some reservations. First, would veterans remain a priority? VA must have proper representation on the governing board of the complex, which would be constructed in cooperation with the University of Colorado. Without proper representation, we cannot be assured that veterans would receive the priority, access, and care they are entitled to.

Second, how responsive could VA be to veterans' needs, given a less-than-complete share of authority on that governing board? VA must be able to adapt to any changes in the veteran population, in technology and in healthcare and business practices to remain able to effectively treat veterans. Without proper control and representation, the partnership may compromise this ability.

If we can receive assurances in the answers to these questions, we will be pleased to support the legislation more strongly. We must be convinced, however, that the partnership will not erode VA's ability to provide timely, accessible, high-quality care to Denver's veterans.

H.R. 2307, A bill to provide for the establishment of new Department of Veterans Affairs medical facilities for veterans in the area of Columbus, Ohio, and in south Texas; and
H.R. 2349, A bill to authorize certain major medical facility projects for the Department of Veterans Affairs

The VFW supports both H.R. 2349 and H.R. 2307. These bills authorize major construction projects at sites around the country to construct and repair inpatient and outpatient facilities, as well as to improve safety.

We continue to feel that VA should not delay major construction projects, if there is already a demonstrated need, even if the CARES process is not yet complete. The process has taken three years already. Just this past week, in a memorandum dated June 4, VA Under Secretary for Health, Robert Roswell, stated that the process will be delayed again as they aim to gather more information. As we, and other veterans' organizations, stated in the Independent Budget, "While

VA planning has ignored its current construction responsibilities and focused exclusively on the CARES promise of guidance, the 'perfect' has become the enemy of the 'good'."

These projects are consistent with sites and construction projects that CARES is looking at. These projects would benefit the veterans VA serves; and in the case of the seismic improvements, would greatly improve their safety and VA's ability to provide services into the future. Going forward with these projects is the right thing to do. Our nation's veterans cannot afford any more delays.

Mr. Chairman, this concludes my testimony. I would be pleased to answer any questions that you or the members of this subcommittee may have.

STATEMENT OF ROBERT H. ROSWELL, M.D.
UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH
U. S. HOUSE OF REPRESENTATIVES
June 11, 2003

Mr. Chairman and members of the Subcommittee,

I am pleased to appear before the Subcommittee to discuss the views of the Department of Veterans Affairs (VA) on H.R. 1720, the "Veterans' Health Care Facilities Capital Improvement Act;" H.R. 116, the "Veterans' New Fitzsimmons Health Care Facilities Act of 2003;" H.R. 2307, a bill to establish new VA medical facilities in the area of Columbus, Ohio and in south Texas; and H. R. 2349, a bill to authorize the Secretary of VA to carry out major medical facility projects in Las Vegas, Nevada, Chicago (West Side), Illinois, West Haven, Connecticut, and San Diego, California and enter a major lease in Charlotte, North Carolina.

Mr. Chairman, my comments will address H. R. 1720, H.R. 116, H.R. 2307, and H.R. 2349, in that order.

H.R. 1720 – Veterans Health Care Facilities Capital Improvement Act

VA supports H.R. 1720, the Veterans Health Care Facilities Capital Improvement Act, which would authorize the Secretary to carry out construction of certain projects using funds appropriated for fiscal years 2004, 2005, or 2006 without requiring specific authorization on an individual project basis. Enactment would accelerate the process for correcting deficiencies in the infrastructure of VA hospitals and help bring VA hospitals in compliance with existing Federal standards. It would also facilitate the future planning of projects.

The physical infrastructure of the VA health care system remains one of the largest in the Federal government with over 5,000 buildings and 150 million square feet in the inventory. It has been a challenge for VA to maintain this aging infrastructure and to make the improvements necessary to meet the challenges of modern health care. We believe H.R. 1720 would improve our ability to respond to immediate needs of the system's infrastructure and to implement CARES.

The bill would require the review and recommendation of a VA board independent of the Veterans Health Administration to evaluate each project before it is proposed to the Secretary for approval. The Senior Management Council within VA, which has been in place for many years, can serve this important purpose. The Senior Management Council provides VA with a comprehensive strategic tool to evaluate capital program requirements. VA intends to continue with its current capital asset management program that includes this independent board. The Department is committed to a set of capital programming principles that ensure that investment decisions are made wisely and efficiently based on accurate data, after consideration of reasonable alternatives, and provide veterans high quality health care in safe facilities where they need it. VA capital asset decision-making continues to evolve and continuously improve. Many external groups including the General Accounting Office have commended the process.

VA is encouraged by the intention of H.R. 1720 to provide the Department the flexibility in funding necessary to make critical improvements to its health care infrastructure. VA's interpretation of the legislation is that it will not alter the opportunity of VA to propose other projects through the traditional authorization process.

H.R. 116 – Veterans' New Fitzsimons Health Care Facilities Act of 2003

VA also supports the intent of H.R. 116, the Veterans' New Fitzsimmons Health Care Facilities Act of 2003, to authorize the Secretary to carry out major medical facility projects at the former Fitzsimons Army Medical Center in Aurora, Colorado. The bill provides the Secretary flexibility in selecting the projects by providing that they may include acute, sub-acute, primary, and long-term care services. H.R. 116 limits project costs to an amount not to exceed $300,000,000 if a combination of direct construction and capital leasing is selected and no more that $30,000,000 per year in capital leasing costs if a leasing option is selected. In addition, the bill places certain limitations on the fiscal years from which appropriated funds can come.

We have been involved in evaluating and planning for a facility for the Fitzsimons site and there is a potential for a joint venture with DoD to provide health care to both veterans and DoD beneficiaries. Many issues still remain including the availability of land, but VA would be able to provide the report to Congress as required if the bill is enacted.

H.R. 2307 – A bill to establish new VA medical facilities in the area of Columbus, Ohio and south Texas

VA agrees that the need for an expanded/replacement outpatient clinic in Columbus, as called for in H.R. 2307, will likely be borne out by the CARES study. The outpatient workload at the existing clinic has increased beyond the planning level projected when the clinic was opened. It is premature to endorse the new facility proposed in South Texas. We are reviewing the need for additional sites in CARES and until that effort is complete, we do not have a position. Without the benefit of additional planning, it would be difficult to accurately estimate the cost of either of the contemplated facilities.

H.R. 2349

In the President's Fiscal Year 2004 budget, VA is requesting authorization for a major construction project at Chicago (West Side), Illinois for a new inpatient tower; outpatient clinic leases in Boston, Massachusetts and Pensacola, Florida; and a lease for the Health Administration Center in Denver, Colorado. In addition we request an authorization for the outpatient lease in Charlotte, North Carolina that received an appropriation in FY 2002.

VA requests an authorization for a lease instead of construction for the Las Vegas replacement Ambulatory Care Center. VA has determined that a lease can be procured sooner than construction and that it will reduce the initial funding required.

The construction projects in the bill for West Haven, Connecticut and San Diego, California are projects that VA identified in our "Priority Major Medical Construction Projects" report to Congress that we submitted in 2002 for the FY 2003 budget. Based on our preliminary data from CARES, both medical centers will retain their current missions and would represent valid projects.

I ask that you also consider authorizing those seismic projects that were listed in the President's FY 2003 budget. The facilities at Palo Alto, San Francisco, and West Los Angeles remain as a critical risk to the safety of patients and staff in the case of a seismic event and remain a high priority for the Department. We are confident that the CARES studies will validate the continued need for these major facilities.

VA supports Sections 1, 2 and 3 of H.R. 2349 and requests that the Subcommittee consider the additional projects that I have mentioned.

The Department strongly objects to Section 4 of H.R. 2349, which prohibits VA from spending funds to dispose of the VA's Lakeside property until after VA has awarded a contract to construct a new bed tower on the VA's Westside campus. VA is proceeding with design of the bed tower project for

Westside, and concurrently taking steps needed to dispose of its Lakeside property as soon as possible through an enhanced-use lease. Both projects are critical to VA's successful realignment of health care activities to improve veteran services in the City of Chicago.

Planning and successful execution of a real estate disposal in a major urban center (like Chicago) is time consuming and complex, taking anywhere from twelve to twenty months to close. A complex enhanced-use project like Lakeside requires VA to take a number of actions before it can actually dispose of the property, including conducting environmental baseline surveys and assessments as well as initiating critical discussions with veterans, local officials, the public, and potential users. For VA to complete these steps and comply with the congressional notification requirements for enhanced-use leases, the Department must act now to be in position to take full advantage of market interest and favorable local conditions. Both activities are now on schedule and actions are progressing independently without adversely impacting progress on either design or construction of the Westside project or planning for the execution of the enhanced-use lease.

Section 4 of H.R 2349 will require VA to cease efforts currently underway, and restart them in approximately 14 months. VA awarded a schematic design contract on November 2002, a design development contract in May 2003 for the West Side bed tower and currently estimates a construction award to be made on schedule in August 2004. Under the current schedule, an enhanced-use lease might be executed as early as spring of 2004. This 14 month hiatus will push that execution back to no earlier than Summer/Fall of 2005.

Linking the two activities, however, will limit the Department's ability to use revenues generated by the disposal of Lakeside to help finance VA's VISN 12 CARES Implementation Plan. Moreover, if award of the construction project is delayed due to reasons beyond VA's control, changing market conditions would likely reduce the Department's return and benefit to veterans.

VA is encouraged by the Subcommittee's interest and actions to improve the infrastructure of VA's heath care system. VA's capital infrastructure has suffered for many years from an uncertainty of the demands and needs for the VA system. I can assure you that there needs to be a strong and viable infrastructure to support veterans' health care and that these bills will enable VA to meet those needs. We look forward to continuing to work with the Subcommittee to ensure that VA continues to fulfill a grateful Nation's obligation to care for its veterans.