DECONSTRUCTING THE U.S. DEPARTMENT OF VETERANS AFFAIRS CONSTRUCTION PLANNING

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
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TUESDAY, APRIL 5, 2011

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

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

Present: Representatives Miller, Bilirakis, Roe, Buerkle, Johnson, Runyan, Stutzman, Filner, Brown, Reyes, Sánchez, McNerney, Donnelly, Walz, Barrow, and Carnahan.

OPENING STATEMENT OF CHAIRMAN MILLER

The CHAIRMAN. I want to welcome everybody here to a hearing entitled "Deconstructing the U.S. Department of Veterans Affairs (VA) Construction Planning." And we are here to examine VA's fiscal year 2012 construction budget request, including the methodology used to arrive at the request in VA's long-term construction outlook.

Unlike previous long-term construction modeling that covered 5-year projections, VA has now put forth a 10-year construction plan using the Strategic Capital Investment Planning or SCIP process. The SCIP process is intended to draw upon past lessons in VA construction modeling, as well as knowledge from the private sector in meeting current needs and anticipating future ones.

Without a doubt a new capital asset planning process presents new challenges and it presents new opportunities. The opportunities are there to provide veterans with state-of-the-art health care in modern facilities closer to where veterans live. The challenges are that VA has an aging hospital infrastructure, a considerable backlog of maintenance projects, an aging veteran population that makes long-term planning difficult and a constrained fiscal environment within which to operate.

VA's SCIP plan has been described as a 10-year action plan that would require a minimum investment of $53 billion to $65 billion over 10 years. Needless to say, given the fiscal environment we are in, that is an ambitious funding requirement, one that we must be sure relies on good assumptions and reliable analysis. And toward that end, I have several questions I would like to have examined at this hearing.

First, I am interested in learning the health care utilization assumptions that were used in adopting the plan, especially given the expected dramatic decline in the veterans population over the next 20 to 30 years.

Second, I am interested to learn whether the $53 billion to $65 billion price tag can realistically be met given the President's fiscal year 2012 request because, if carried forward annually for 10 years, it would only meet half the cost.

Third, I am interested in learning about the alternatives VA considered to meet its service delivery needs other than in-house construction. Were partnerships with other Federal providers adequately explored, and what about public-private partnerships? In short, were all available options to meet veterans' needs on the table and fully considered?

Fourth, it is my understanding that the SCIP plan does not include costs associated with up-front facility activations or annual operating expenses and I'm interested to learn whether those costs ought to be known before Congress adopts one proposal over another.

And finally, I am interested in learning about VA's recent performance in its management of construction projects. If the Committee can be given some assurances that VA has been a good steward of the construction funding that Congress has already provided, it will help in the decisions that we must make moving forward. I believe it is imperative that VA use full transparency in presenting its decision-making process on how every dollar was spent once it was appropriated.

VA must also ensure that all cost effective options are considered, all bias acknowledged, and due diligence conducted as it moves forward in its capital asset planning. Comprehensive planning on the front end will prevent massive cost overruns and project delays down the road.

In the end, our overarching objective is clear. Veterans expect and we should deliver the best that 21st Century health care has to offer. This hearing begins a discussion of how we will collectively chart a path towards meeting that objective.

I do appreciate everyone's attending at this hearing and now I yield to the Ranking Member for his opening statement.

[The prepared statement of Chairman Miller appears on p. 40.]

OPENING STATEMENT OF HON. BOB FILNER

Mr. FILNER. Thank you, Mr. Chairman. I ask that my statement be made a part of the record, and I just want to comment briefly. Mr. Gould, I want to figure out what is the clever bureaucratic thinking behind putting forward a 10-year plan and asking for a budget appropriation that will take 20 years to meet the 10-year plan. There must be something really clever there that I am missing because it looks like you are putting together a 20-year plan.

But I don't understand it. If you are going to come up with a 10-year plan and you say you need X amount of dollars and you ask for half of that, I am not sure what the point is. Why have a plan if you are not going to even ask for it to be implemented? I will put my full statement in the record, Mr. Chairman.

[The prepared statement of Mr. Filner appears on p. 41.]

The CHAIRMAN. Thank you, Mr. Filner. Thanks to the first panel who is with us today. We have the Honorable W. Scott Gould, Deputy Secretary of Veterans Affairs. Thank you for being with us, sir. And Mr. Glenn Haggstrom, Executive Director, Office of Acquisition, Logistics, and Construction. There are other folks with you today, and I would ask you, Deputy Secretary, if you would introduce them to us as well.

Your complete written statement will be made part of the record, and you are recognized, sir.

STATEMENT OF HON. W. SCOTT GOULD, DEPUTY SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY GLENN D. HAGGSTROM, EXECUTIVE DIRECTOR, OFFICE OF ACQUISITION, LOGISTICS, AND CONSTRUCTION, U.S. DEPARTMENT OF VETERANS AFFAIRS; PATRICIA VANDENBERG, MH, BS, ASSISTANT DEPUTY UNDER SECRETARY FOR HEALTH FOR POLICY AND PLANNING, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; JAMES M. SULLIVAN, DIRECTOR, OFFICE OF ASSET ENTERPRISE MANAGEMENT, OFFICE OF MANAGEMENT, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND ROBERT L. NEARY, JR., ACTING DIRECTOR, OFFICE OF CONSTRUCTION AND FACILITIES MANAGEMENT, U.S. DEPARTMENT OF VETERANS AFFAIRS

Mr. GOULD. Mr. Chairman, thank you so much, Ranking Member Filner, distinguished Members of the House Committee on Veterans' Affairs. Thank you for the opportunity to appear before you today to discuss the Department of Veterans Affairs construction planning.

Mr. Chairman, thank you for introducing Glenn Haggstrom, immediately to my right. May I also introduce Jim Sullivan, Director of our Office of Asset Enterprise Management, Office of Management, and Pat Vandenberg, Assistant Deputy Under Secretary for Policy and Planning. These are, respectively, the people leading our construction, financial overwatch and health care policy and planning, so I think we will have a very full discussion today.

It is a privilege for me to represent Secretary Shinseki today and the hard-working people at VA, the employees who each and every day provide veterans and their families with care and benefits second to none.

Our mission at VA is to provide the best possible health care and services to veterans wherever they reside. Next to a well-trained staff and state-of-the-art technology, our capital infrastructure is essential to delivering high quality services.

Today we have a comprehensive array of capital infrastructure across the Nation, including over 1,400 points of service with a replacement value of over $100 billion. Together they comprise the largest direct health care system, the largest cemetery system and one of the largest benefits services systems in America.

But it is also true that the average age of our buildings is over 60 years. During these years, the medical needs of the veterans we serve have evolved. In general, they have chosen to live in different cities and towns across the country. Their demand for care and benefits has increased. Their needs for certain kinds of care, like

polytrauma, post-traumatic stress disorder (PTSD), traumatic brain injury (TBI) and other injuries common to our ongoing conflicts have changed as well.

Consequently, we at VA are engaged in a constant effort to do three things. Number one, anticipate the many changing factors that influence our ability to care for veterans. Number two, determine the location, size and functionality of the buildings that will serve our veterans in the future. And last, request the funding that will meet future needs while fulfilling the promise of access to high quality care today.

Our capital infrastructure planning factors in new models of care and many technological developments that were not available 10 years ago. Telehealth and telemedicine, for example, are critically important in providing care to veterans in remote areas and often to those with chronic health care needs. As a result, we can provide care to more veterans with less infrastructure—fewer hospitals, for instance, than we had just a few year ago.

We know that many prosthesis that once required inpatient care are now delivered through outpatient care. And we know that veterans and taxpayers are often served best in the veteran's own community. We also have new ways to finance our capital infrastructure. For example, we are leveraging non-governmental and private-sector interests and expanding our capital infrastructure through investment programs, including the Enhanced Use Lease, or EUL. We have shed a number of under utilized and vacant buildings through our Building Utilization Review and Repurposing Program. We not only buy facilities, but we lease them, about 1,600 in our system today.

And finally, in areas where the sparse population makes infrastructure impractical and inefficient, we continue to use contract care services for veterans' needs.

The imperative remains the same—ensure veterans and our employees have access to safe and secure facilities in which to receive and provide care and services. Serving veterans now and in the future, therefore, is the principal driver of our planning infrastructure and the overarching goal of the new Strategic Capital Investment Planning process, known as SCIP.

To this end, we have developed a new tool to prioritize the capital needs across VA's three administrations, as well as across the budget accounts through which capital funding is provided by Congress. SCIP is a rigorous capital planning process that quantifies and prioritizes the need to repair, upgrade, or replace VA's aging infrastructure and address the current and future needs of America's veterans within the context of prudent capital investment decision-making.

SCIP means that VA capital decisions are no longer made in administration or program stove pipes. By taking a corporate approach to capital planning, SCIP ensures that our capital investments are considered together and are prioritized according to the same criteria. In my written statement I describe how SCIP supports VA's top three priorities, namely to increase access, eliminate the claims backlog and end veterans' homelessness.

I also outline our budget request for fiscal year 2012 and I emphasize that we are working toward achieving our priorities, while

ensuring the best possible use of taxpayer dollars. In fact, SCIP is part of a larger effort to establish and reinforce the importance of right behaviors, disciplines, processes and leadership to become a more effective, accountable and efficient department.

In summary, the VA capital plan and associated fiscal year 2012 budget before this Congress seeks to support the requirements necessary to meet the needs of those who have served this country and their families for years to come.

Mr. Chairman, Members of the Committee, this concludes my remarks and I thank you, again, for the opportunity to be here today and to respond to your questions.

[The prepared statement of Mr. Gould appears on p. 42.]

The CHAIRMAN. Thank you very much. The SCIP process does project future space needs through 2018, however, it is my understanding that SCIP is based on the same Milliman utilization projection data that VA uses for the enrollee model for the budget.

In 2008, RAND reported in a review and evaluation of the VA enrollee health care projection model that this model is useful for short-term budget planning, but has limited utility for longer term planning and policy analysis.

So my question is, how can you accurately project needs to 2018 using the Milliman data and is this a flaw in SCIP?

Mr. GOULD. Mr. Chairman, we use a variety of methods to try to forecast our demand in the system, and you are quite right. The purpose of our modeling is to look as far into the future as we can. In fact, we try to push ourselves out to a 20 year point. We use our Milliman model to help accomplish that, and it has proved quite accurate in the near term.

I would like to ask Pat Vandenberg to give you a little bit more detail into how the model is used.

Ms. VANDENBERG. Thank you for that question. Yes, RAND did acknowledge that there were some challenges in the long-term projections, and since the RAND study has been received, we have looked for ways to strengthen the reliability of the model. We pay particular attention to better understanding the cohort that is enrolled with us, and in particular the needs of veterans coming from the current conflicts.

We have also looked to crosswalk our experience with the model to other projection tools such as those that are used by Medicare to project the demand for services. Since many of our veterans are over 65, we can look at the reliance factor, not only within our system but also within Medicare.

The CHAIRMAN. VA's total capital budget request for fiscal year 2012 is relatively low and both I and the Ranking Member, have both addressed that in our opening statements, when compared to the SCIP magnitude costs over 10 years. Given the fiscal constraint that we are in, is the SCIP plan realistic? And further, as I said, it does not include activation costs or annual operating expenses. Don't you think we should know what those costs are before embarking on such an ambitious long-term plan to meet gaps in service?

Mr. GOULD. Mr. Chairman, first of all, I think the SCIP's central contribution to the discussion that we want to have about serving our veterans now and in the future is to transparently and clearly

define how big the problem is. Up until this point, there were no figures available over a 5- or 10-year period that would have allowed this Committee and others to evaluate exactly where we were relative to this problem.

It is an eye-watering number. I frankly admit that. We also think it is a necessity to be able to build the capital infrastructure that our veterans need for the future. At the same time, every Member here would frankly admit that we are in a tough situation in terms of the budget. Our resources are constrained. We need to make sure that every dollar we have counts. And it was with those two needs in balance, both the large 10-year demand and the near-term constraint on our budget, that we arrived at a total figure of $2.8 billion for major, minor, non-recurring maintenance (NRM), and leasing in our system.

If you do look at that number and look back over the past decade, it is a number that is about average for our investment. Can and should we do more? Of course. But in fiscal year 2012, given the balance of constraints and the need to deliver current services to our veterans, we believe that we arrived at the right number for the VA.

The CHAIRMAN. But what about activation costs and operating expenses? Isn't that something that should be factored in that we should be made aware of?

Mr. GOULD. It is very important and you will note in the budget request, we clearly identify that it is not included. What we are doing now is developing a model to help us better estimate what those activation costs are. You will note if you look at our last 10 years of performance, that building large infrastructure and major construction has not been something we have done often. We are opening new facilities now for new hospitals across the U.S. over the next several years, and what we found is that our ability to accurately estimate what those activation costs are has atrophied.

And so in recognition of that, we simply identified in the model that there were additional activation costs to come, clearly stating that in the President's budget proposal, and now what this team is doing is working on developing an accurate estimate, which we would be happy to share with the Committee and provide to you.

[The VA subsequently provided the following information:]

> The Strategic Capital Investment Planning (SCIP) 10-Year Action Plan is an important planning tool that identifies service gaps (geographical access, utilization, facility condition, space, etc.) and assists VA in planning and identifying the capital projects (and non-capital solutions) to close these gaps.
>
> As stated in our budget submission, the SCIP Action Plan represents a snapshot in time providing the magnitude costs and specific projects required to meet existing and projected critical infrastructure gaps, while honoring our commitment to serve Veterans in facilities that are safe, modern, and within a reasonable traveling distance for Veterans.
>
> For a given project, SCIP-generated estimates are refined as the project moves further along in development (action plan → business case → prospectus → final design). While activation and operating costs were not reported in the 2012 SCIP Plan, they are an important element in VA's planning process. VA is currently in the process of developing a robust and uniform methodology for estimating and including these costs in the 2013 SCIP Plans.

The CHAIRMAN. I am a slight bit over my time, but I would like to take the prerogative to ask one question I think all of us want

to hear an answer to. We are currently in ongoing negotiations to keep the government open and operating through the end of September. Nevertheless, many of our constituents want to know how their services might be affected if there is, in fact, a government shutdown, and we know, with the exception of VA health care, which is already fully funded for the year, can you describe for us the effect of a shutdown, what it would be on VA programs, and certainly as the Chief Operating Officer, you have a contingency plan in place, and if you could, let us in on that.

Mr. GOULD. Mr. Chairman, first of all, I have tremendous sympathy for your constituents and frankly our employees as well, who are quite concerned about the prospect of a potential shutdown.

The first thing I want to say is, we believe that that shutdown can still be averted and I know I share the view with many here in this room that our negotiating teams can take that action to avert a shutdown.

We are also very grateful for the foresight of this Congress, prior Congress and Committee in providing a 2-year appropriation. I think one thing that you would hold up to Members calling with concern about what might happen to them that with an advanced appropriation, we are one of the very few agencies that has about 86 percent of our funding for this fiscal year already in place, so those operations would continue without effect.

I don't want to speculate on what activities would be adversely affected by a possible shutdown, but we have done quite a lot of work to try to update our plans and get some insights on that. I could share with you from 1995/1996 that, to take an example, our Voc Rehab counseling services were not offered and you can see that for folks looking at reintegrating with jobs in the private sector who are trying to be employed, how important that would be, and it was not available in 1995/1996.

The CHAIRMAN. Well, I appreciate your attempt to not answer the question, however, I do think that you need to speculate, especially here, particularly on VA construction loans, the construction programs that are ongoing today, burials at our national cemeteries, GI Bill recipients, you mentioned Voc Rehab, disability compensation and pension. I mean, just those few areas, you know, I just, I don't see how you can't—I mean, you've obviously speculated somewhere. We are real close to one of two things, either resolving the issue that's been left to be resolved or, unfortunately, seeing the government shut down.

Mr. FILNER. Can I follow up, Mr. Chairman? When you said you don't want to speculate, and the Chairman said that we are a couple of days off, then you must have a plan. If you don't, I'd send you back right now to do one. Are people going to get their checks? Are they going to get their services, as the Chairman pointed out? Who is going to go to work and who is on furlough? You must have a plan. If you don't, then I guess I would ask for your resignation now, but come on. The Chairman asked you a question. You don't want to speculate, but there has to be a plan. Who is going to be essential? Who is not essential. Who is going to get their checks? Who is not going to get their checks? You have to know something about that.

Mr. GOULD. Yes. Mr. Chairman, Ranking Member Filner, obviously there has been a lot of activity to update our thinking. We are responsible for being prepared for a variety of contingencies. We are a couple days out from the prospect of a shutdown. The entire management team at VA shares with you a concern for our employees and the veterans who might potentially be affected by a shutdown, but I believe that it is still possible to avert a shutdown and I hope that the negotiating teams charged with that and who are taking that responsibility very seriously can proceed to reach an agreement unencumbered by any further discussion on potential impact.

The CHAIRMAN. If the government shuts down Friday at midnight and we have funerals and burials scheduled for next week, what happens?

Mr. GOULD. Reflecting back on the 1995/1996 experience, I can tell you that those burials would continue at a modifying rate. It might not be possible to conduct every burial as it was requested in terms of the specific day, but obviously out of a regard for the seriousness of the issue and requests on the part of the families in 1995/1996, the government reached the conclusion that those services would continue.

The CHAIRMAN. Mr. Filner.

Mr. FILNER. I know this was not the subject of the hearing, Mr. Under Secretary, but I am very disappointed in the answer. We have to know more. Some of us are going to argue that it is necessary to avoid a shutdown. Some are going to argue, no, it doesn't matter. Every agency should tell us what are the consequences. Again, is somebody's disability check going to be cut? Is somebody's disability claim going to be adjudicated, or not? Are contracts going to be let?

These are rather obvious questions, and surely you have considered them. So, you have to answer some of them. Do we have to go down everything, because the Chairman asked you about burials? So, I will ask you about disability claims or disability checks. Are they going to be paid or not going to be paid or, how about the GI Bill? Are they going to get their checks on time?

I mean, we can go on and on, but you have to give us some specifics here.

Mr. GOULD. Well, perhaps I can be helpful on the disability claims. Looking back to the 1995/1996 experience where government went through this very wrenching process in conjunction with Counsel and after reviewing the Appropriations language and impact, those checks did flow during that time. So I just would ask the Committee to recognize that with respect to our veterans, their health care will be continued by virtue of the fact that we have an advanced appropriation. About 86 percent of our budget is covered over that 2-year period.

And so as you turn to your constituents with obvious concern and care, if they are working in VHA, the Veterans Health Administration, then clearly they fit in a situation where funding has already been provided to them, so they would——

Mr. FILNER. What percent of the remaining employees will be considered essential or non-essential, roughly?

Mr. GOULD. Well, we don't know what that final number is. The Secretary will have an opportunity to make a final decision on that on Friday of this week. We hope that it doesn't come to that and that the negotiators are able to avert a shutdown in the hours and days ahead.

Mr. FILNER. Well, as I said, I think we need a far more specific—I think the whole administration should be telling the Nation what the possibility is or what the situation is so that everybody knows.

My original question that I asked, I am not sure that I got a good response to it. If we are estimating in your first 10-year plan, it is around $6 billion a year, roughly?

Mr. GOULD. Right.

Mr. FILNER. And you are asking for less than half, plus you ask for a contingency of about $1 billion. I don't understand the budgeting process that when you rolled out a 10-year plan, you didn't ask for enough to fully implement it. You did in the first year, but we are going to need you to estimate how much it is for the plan so we get stable funding and we put in the $6 billion a year or whatever you need. At least that is what I would think if it was my house or my business. I would be trying to do that, right?

So you asked for half and then you asked for some contingency money that the Chairman and I agreed to. We took your SCIP plan a little more seriously maybe than you did, and put that money, or suggested that money go into construction. I still don't understand the process that led to that. There are going to be constraints every year from now on and if you are not going to ask for the $6 billion every year, then you are going to keep falling behind. As I said, your 10-year plan becomes a 20-year plan, which is what you said you would like to get. Well, you got it. It is going to take 20 years to take care of the 10-year efforts and then you will have a new 10-year plan.

I just don't understand how all that was decided.

Mr. GOULD. Let me try to assist on that. First, look, it is a big number. We know it is a substantial investment on the part of the country as we look forward. I would point out that it is about 5 percent of the total amount of money that we are going to spend over the next decade on our veterans. Current course and speed, about $1.3 trillion. That is a lot of money.

Now, if we were thinking, to use your analogy of our own home or our own business, having first tried to clearly identify what the requirements were, we would then step back into our current situation, loan capacity, free cash, availability of funds, and then we would decide on a specific number and that is exactly what we did. We took into consideration our big picture, a big aggressive number here that we need to move forward on and the reality of our current budget environment.

I think a lot of folks around this table are confident that our country is going to spring back, that we are going to do better in the future and that these dollar constraints that we are facing now are not going to be the same as the ones we face in out years. As so there is a belief that we will be able to, in a year-by-year basis, return to the funding question with the number clearly and transparently stated, a standard out there for what we need to achieve and each year the administration will come back and evaluate that

and obviously request funds that we think are appropriate relative to the other expenses that we have for current medical services benefits and burial in VA.

So it is not just a pure decision that we make, construction alone, but relative to the other needs that our veterans have.

The CHAIRMAN. Mr. Johnson.

Mr. JOHNSON. Thank you, Mr. Chairman. I need to express also my disappointment in the vagueness of the answer. Indicating that burials will continue at a modified rate sounds to me like some of them will, some of them won't, some of them maybe, and I doubt seriously that that is going to be an acceptable answer to the families of our veterans or to the veterans themselves. It is certainly not an acceptable answer to me, but I will leave it to the Chairman to determine where we go with that. I am really disturbed by the vagueness of that answer.

If there are contingency plans, this Committee has asked what those contingency plans are and all we are being told is that they exist, but you can give no specifics and no details on them. I find that particularly disturbing.

As you know, despite the various efforts that the VA has undertaken to realign its capital assets, it is evident from the testimony presented here that there is a lot of work to be done in order to create a more efficient, transparent and cost effective approach to the VA's capital asset planning, approval and budgeting process.

We share a common objective of assisting our Nation's veterans and providing them with the health care benefits and services that they have earned and are entitled to. It is unacceptable when resources and funds are being wasted on government inefficiencies, instead of directly caring for our veterans. And furthermore, a cost analysis assessment of VA's construction projects would not only illustrate possible cost savings alternatives, but is required by law, and I welcome the opportunity to discuss the VA's construction planning and budgeting process and to work with my colleagues on this Committee to address some of these critical issues that can and must be resolved.

Let me ask just a couple of quick questions. Peter Heckathorn, Executive Vice President of Sacred Heart Health Systems in Pensacola, Florida, noted in his testimony, submitted for the record, that his organization uses an independent review process that is quite detailed. Has the VA ever considered using an independent review process to make an unbiased decision, giving all possible alternatives related to VA facilities? And if so, why hasn't it been adopted.

Mr. GOULD. First, Mr. Johnson, if I could say that the objective of the SCIP process is exactly what you are calling for in your preliminary statement there—for greater business-like approach to our investment decisions. We are doing cost effectiveness analysis. We are developing a business case, over 930 of them this year alone.

We have set up a board, internal to VA, to evaluate and stringently review and prioritize each of these investments and then, most importantly we have applied a set of decision criteria, six major criteria that are used to rank and prioritize each of these so that we absolutely are sure that these are the highest priority, best

value investments that we could make as an agency. So this is the part—the reason behind SCIP is to get at just the issues that you have identified a moment ago. We think we are doing it here.

Mr. JOHNSON. How long does the VA estimate that it will take to complete the major and minor construction projects that are ongoing? Do you have a timeline?

Mr. GOULD. Let me ask Glenn Haggstrom to give us a sense. As you know, when we take these on, we spread them out over a year. There is a reason why we do that. We focus on design first, make sure we get that right. Once the design has been done, then when we go to a bid, the construction firms are clear about what it is they are going to build for us, and then we can manage the implementation and construction of those facilities over time.

Mr. Haggstrom.

Mr. HAGGSTROM. Congressman, when you look at the large major construction projects, much depends on the scope and complexity of those projects and the phasing that may be necessary to complete those projects. When you look at a smaller facility or a national cemetery, we can look at probably an 18- to 24-month completion time from the time we start to turn dirt. For a major medical facility, it is a 36- to 40-month period of time to complete that facility and turn it over to VHA for occupation.

Mr. JOHNSON. Okay. All right. Thank you. Just one quick follow up because I've only got 20 seconds left. Mr. Secretary, back to your comments about SCIP and what it provides, would you object to an independent third-party review of the SCIP plan to validate your findings?

Mr. GOULD. Let me take that question for the record, Mr. Johnson. I think, in principle, the idea of oversight and review is welcome. This Committee is engaged in that right now. We have reached out to our veteran service organizations (VSOs). We have employed an internal board of subject matter experts in this area. Our techniques and processes recognized by the U.S. Government Accountability Office (GAO) are among the best practiced in government and we have drawn on private sector input.

However, what we decide obviously has a tremendous acquisition and procurement sensitivity. So it is with that simple reservation that I would ask to take the question for the record and respond to. On a common-sense basis, it makes a lot of sense. Would we be revealing competitive information on those major projects? I am not quite sure, and I would ask the Committee to afford me the chance to provide that answer in writing.

Mr. JOHNSON. I will look forward to your answer. I yield back, Mr. Chairman.

[The VA subsequently provided the following information:]

> The Strategic Capital Investment Planning (SCIP) is a process comprised of the following four components: gap analysis, strategic capital assessment, 10-year action plan, and business case. SCIP focuses on identifying service gaps and developing a plan to significantly reduce/eliminate those gaps over a 10-year period. This process is data driven, but also includes input that is qualitative. The end result is a list of capital projects for the budget year that will contribute to the closure of service gaps. Each of the four components and the process as a whole come together in a way that allows a capital project to be tracked from beginning to end. SCIP also encourages the use of non-capital solutions where possible. The Department welcomes an

opportunity to demonstrate the transparency of this process via independent analysis/review.

The CHAIRMAN. Thank you very much, Mr. McNerney.

Mr. MCNERNEY. Thank you, Mr. Chairman. I think it is important what you have tried to accomplish here, looking ahead 10 years, 20 years, certainly with the veterans issues. This is a long-term project. As we have seen, there are veteran independents still from World War I and World War II in the system, so the need is going to continue to grow. There is no question about it. Let me share one of my frustrations in my particular district. We have an agreement by the Veterans Administration to put in a new facility and it took about 2 years for the Agency to decide what county to put it in, and it has taken another year now that they have decided what county to put it in, whether to put it in the City of Stockton or whether to put it in the French Camp area and this is very frustrating for our veterans who are looking forward to the service, for the unemployed people that might be employed and so on. And it is also something that is going to increase the cost.

Now, you know, every year you delay a project, the cost goes up by 5 percent or so, so you know, in terms of long-term planning, I would suggest and I would urge that the Department—and I am not sure that your Department's directly responsible here, Deputy Secretary Gould but making timely decisions is an important function and I haven't been satisfied with what has happened so far.

I don't know if you want to respond to that or not, but it certainly had been a frustration of mine.

Mr. GOULD. Sir, I just do want to express my concern for our need on the VA's side to make timely decisions on matters like this.

We are making those decisions, unfortunately, in an environment where lots of folks get to second guess and review and come around a second and a third and a fourth time on all of those decisions.

So when we use our SCIP process to identify places where we can put a new facility, we start with a gap analysis that is rooted in our best understanding of the community needs and the veteran needs in that location. If you would like a specific response to the location in your district, I might ask Bob Neary who is with us today and sitting behind here to provide you a direct answer to your question about that facility.

Mr. NEARY. Thank you, sir.

The CHAIRMAN. If you could, use the microphone and identify yourself, please.

Mr. NEARY. Sure. Mr. Chairman. My name is Robert Neary. I am the Acting Director of the VA's Office of Construction and Facilities Management. With respect to the site selection for the clinic, we are very close to doing that. We are in the final stage of the environmental assessment. The comment period from public and government stakeholders closes in about a week, and we will, as quickly as possible after that, make a recommendation and make the selection of the site.

Mr. MCNERNEY. Thank you. I mean, I hope this isn't always the case that it takes 3 years to make a decision like this because it is going to end up costing more and it certainly makes people frustrated about the VA in general, about its ability to respond to the

needs of our veterans, so please keep that in mind in your rule making.

I have another question. To what extent do you feel that having building construction and upgrades accomplished in a timely and cost effective manner can help reduce homeless veterans populations? So, in other words, is this process, you know, impacting the Secretary's prime goal of getting veterans off the street?

Mr. GOULD. Thank you, sir, for that question. Absolutely. As I mentioned earlier in my remarks, one of our top three priorities for VA is ending homelessness, so it was natural for us to look to our capital stock and infrastructure and ask the question, "Where could we use these buildings to house homeless veterans?" And so we have been doing that and are continuing to do that. We would ask this Committee for their help and assistance and making sure that the Enhanced Use Lease process is reauthorized after this year. If we do not have it reauthorized, we will put in jeopardy about 1,600 beds for our homeless veterans, so this is very important. I would ask the Committee to assist in whatever way possible.

The Enhanced Use Lease, as I described earlier, is a way where we leverage private-sector investment to be able to provide these facilities. I think it makes a lot of sense from a business prospective. And as I said earlier, 1,600 beds at stake if we can't make this happen.

Mr. MCNERNEY. Well, I certainly would ask that you keep us, the Committee, the Chairman, myself, informed about this progress because it is important to myself, it is important to every Member of this Committee to keep veterans off the streets.

Mr. GOULD. Yes, sir, we will.

Mr. MCNERNEY. And any impediment you feel is not appropriate, I urge you to contact us and make things happen.

Thank you, Mr. Chairman.

Mr. GOULD. Thank you.

[The VA subsequently provided the following information:]

SCIP is a tool used to prioritize capital projects that contribute to the closure of service gaps and completion of Departmental initiatives. The decision criteria used to prioritize those projects is comprised of the many competing priorities within VA. SCIP decision criteria include homelessness as one of the Departmental Initiatives and each project is scored related to how it addresses Veteran homelessness. The SCIP process includes all Enhanced Use Lease (EUL) projects, in addition to the other construction programs, as a way to meet identified service gaps. EULs can assist in meeting space, energy, condition, and functional gaps, as well as providing options for homeless Veteran housing. Each Veterans Integrated Services Network (VISN)-submitted action plan must include a description of how the VISN will address the departmental goal of ending homelessness in 5 years. This may include EUL or other options for addressing local homeless issues.

As a related capital asset portfolio management tool, VA undertook a strategic effort to identify and repurpose unused and underutilized VA land and buildings nationwide in support of the VA's goal to end Veteran homelessness. The Building Utilization Review and Repurposing (BURR) initiative is assessing existing real estate assets with the potential to develop new housing opportunities for homeless or at-risk Veterans and their families through public-private partnerships and VA's EUL program.

The Department's EUL authority allows VA to match supply (available buildings and land) and demand among Veterans for housing with third-party development, financing, and supportive services. This approach has multiple benefits: helping to reduce homelessness among our Veterans while leveraging an underutilized asset, reducing the inventory of underutilized real estate, and transferring the operation and maintenance costs to

a developer. Other internal and external potential reuse opportunities will be explored for buildings determined unsuitable for housing.

The entire inventory of unused and underutilized VA land and buildings is incorporated into the SCIP process.

The CHAIRMAN. Mr. Runyan.

Mr. RUNYAN. Thank you, Mr. Chairman, and I missed it, but thank you for the moment of silence to our colleague. He was—I know, personally campaigning against him, he was a great advocate for veterans and I appreciate that gesture.

Mr. Secretary, I have had similar comments that Mr. McNerney had. I have a situation, much like I think a lot of us do, where I represent Joint Base McGuire-Dix-Lakehurst and, you know, we have a community-based outpatient center (CBOC) medical facility on the base. How does the SCIP address the access? I hear from veterans all the time that they like the facility. I have been to the facility. They say it is suitable, but it could be better. But the access to our veterans to actually get on to the military base, a lot of them are ignoring it and then, you know, we are building the problem, you know, whether we have enough facilities or they are not getting to them, are we creating more medical problems down the road that we are going to have to address, and that is my number one thing, is access, and is it accounted for in that process?

Mr. GOULD. Let me have a general statement on that, and I think Mr. Neary might be able to address the specific concerns that you have for your CBOC. You said in the Lakehurst area?

Mr. RUNYAN. On the old Fort Dix, yes.

Mr. GOULD. On the old Fort Dix. You know, part of what we are purchasing here, with the big price tag, what everybody sees topping out at $65 billion, plus the activation cost, is over 8 million square feet of additional space that over the next 10 years is going to do a couple of things for us. One, it is going to move our access from 67 percent up to 70, and two, it is going to reduce our overcrowding and overutilization of our buildings from about over 120 percent down to 95.

So the big picture is, we look at the system, where veterans are going, where their—what their needs are. This investment is about improving access and building utilization. Now, in your specific area where that all comes to roost and your concern for your Members, let me make sure we give you an answer that we can on the Lakehurst situation.

Bob.

Mr. NEARY. Certainly. Mr. Runyan, the SCIP process affords the opportunity to evaluate the opportunities and needs for expansion or relocation of a facility and I have to provide for the record the details about the Fort Dix situation. Be glad to do that.

Mr. RUNYAN. I would appreciate it because, you know, it is a unique situation with the fact that there are over 65,000 veterans in the district, and McGuire-Dix-Lakehurst being a Reserve Guard post, a lot of those people are going to tend to stay there after they come out of the conflicts we are in, creating a larger demand. So I appreciate your answer and I yield back, Mr. Chairman.

[The VA subsequently provided the following information:]

Veterans access the Fort Dix CBOC by showing their appointment letter or Veterans Identification Card at the gate. The Fort Dix CBOC also provides a copy of the daily clinic schedule to the base Visitor Center the night

prior to each business day. The SCIP submission for the Philadelphia Veterans Affairs Medical Center, the CBOC's parent facility, proposes increasing the size of the Fort Dix CBOC in 2013, possibly by moving off Joint Base McGuire-Dix-Lakehurst and into the community. Moving off the base would eliminate any challenges with ease of access to the CBOC. The project is currently under review and a final decision by VA is anticipated by the end of Fiscal Year 2011.

The CHAIRMAN. Ms. Sánchez.

Ms. SÁNCHEZ. Thank you, Mr. Chairman. Deputy Secretary Gould, in his written testimony, Raymond Kelley of the Veterans of Foreign Wars (VFW) notes that, "Community Based Outpatient Clinics are crucial to meeting the needs of veterans as the veteran population shift."

I am wondering if you feel confident that the VA's budget request and the likely Congressional funding that you will be receiving will be sufficient to continue to place CBOCs where they are needed, not just this year or next year, but in years to come?

Mr. GOULD. Ms. Sánchez, thank you for that question. Obviously, over the next 10 years we believe that our SCIP investment plan appropriately emphasizes the use of what we call tertiary, excuse me, primary care. And that primary care, embodied in the community-based outpatient clinic is really—the whole purpose of that is to move the point of care closer to our veterans, to make the access easier for them. Our goal is to have 70 percent of our veterans within a 30-minute drive to that facility. So we see a need for an increased number of CBOCs and increased square footage on our secondary and tertiary facilities, to be able to meet that combined need.

Ms. SÁNCHEZ. Okay. I am pleased to hear that, but I am sort of a little concerned because the SCIP seems to rely so much on increased funding in the out years and I am wondering if you can explain your reason for believing that substantially more funding is going to become available down the line. I mean, we are living in very challenging economic times and challenging, certainly, for budgets at the Federal level.

So I am sort of curious as to why you believe that there will be more funding later on down the line?

Mr. GOULD. Yes, ma'am. And this is obviously a huge need that we have. It is going to cost a lot of money. And to the best of our ability to calculate and forecast, this is the size of the demand that we have for our veterans. We have to step up to providing these facilities. Our number one priority is to obviously make sure that those who do go into battle have the equipment and the training they need and that this VA is there for them when they return home.

And so this quantification through SCIP is all about saying this is a very big number, we are going to have to go out and fund this over a 10-year period. Our assessment of this year's funds availability, relative to the other services that we have to continue to provide without interruption was such that we arrived at the number of $2.8 billion for our veterans in 2012 in this Capital Investment. It will need to be more in out years, clearly as we go forward, and my hope is that Congress will be able to find those funds.

Ms. SÁNCHEZ. So the hope is that down the line Congress will fund it at a higher level than now?

Mr. GOULD. I am not asking for additional funds——

Ms. SÁNCHEZ. No, I realize you are not asking for additional funding now. But you are sort of relying on the fact that Congress will be generous down the line and fund it at a higher level.

Mr. GOULD. No, ma'am. The President also will take a look at his budget for fiscal year 2013, and again, go through the same process. So there will be a number of opportunities to step forward with a specific request in 2013 and beyond that we believe will and can achieve this total investment over a 10-year period. It is just that numbers in 2012, which obviously the only numbers that have come forward on the budget right now are at $2.8 billion.

Ms. SÁNCHEZ. Okay. I am not convinced that that is the best way to budget, but you and I will just have to agree to disagree on that.

In your written testimony you noted the importance of Enhanced Use Leases, EULs, in getting homeless veterans off the streets and into homes, but I am hearing concerns from veterans back home that not enough of the benefits of EULs necessarily go to veterans and that veterans would like a more transparent EUL process in which they can give input and advice. I'm wondering if you have heard of similar complaints. And whether you have or you haven't, can you explain what might be, or what is being done to maybe address that concern.

Mr. GOULD. Yes, ma'am. First of all, the EUL, as a I described earlier, is an incredibly useful tool for VA. Since about 2006 we have saved a quarter of a billion dollars of taxpayer money by the use of EULs. What it does is leverage private sector and NGO investment in facilities that we would otherwise have to build. With direct capital infusion we can spread those costs out over time. So it is extremely useful.

I would like to ask Mr. Sullivan to talk a little bit about the EUL process that we use, how it includes stakeholder input and how we make sure that there is transparency in the process.

Ms. SÁNCHEZ. Okay.

Mr. SULLIVAN. Let me try and respond to that question about transparency in the EUL process. All EU projects and EU efforts require a public hearing. We do it locally at the site and give notice to all of the interested stakeholders in terms of the VSOs, in terms of the local community, the local municipalities or counties or other local elected officials.

We also notify Congress prior to that hearing to make sure we get the input of everybody, if there are particular issues that are there. Some EU projects there are relatively no issue. Other projects there are issues, most of them end up being to deal with folks, not necessarily veteran groups or veterans, but local jurisdictions that may have issues in terms of a homeless veteran project going in and what does that mean for the community, not necessarily what it means for veterans, but are there other issues.

If there is a particular issue on the one you talked about, we would be happy to meet with you and find out what that is. It is a very give-and-take process of developing of an EU and we should address that and we will look at that situation.

Ms. SÁNCHEZ. I appreciate the offer and I would appreciate an opportunity to discuss those specific concerns with you.

[The VA subsequently provided the following information:]

> At the onset of every proposed enhanced-use lease (EUL) project, the local VA facility in collaboration with the EUL Program office hosts a public hearing to allow Veterans, the community, and other stakeholders the opportunity to learn about the proposed project and provide input into the development concept. Once the project is underway, the selected developer is required to comply with all local and State building and occupancy codes and ordinances. The EUL process is designed to afford Veterans and the public opportunities at different intervals in the project to provide input whether directly to VA or through the local governance process.
>
> A meeting with Representative Sánchez was scheduled on Tuesday, May 24, 2011, to continue the dialogue regarding transparency and input from Veterans on VA's EUL program.

Ms. SÁNCHEZ. I am wondering if I can beg the indulgence of the Chairman for an additional 30 seconds to ask one last questions of the Deputy Secretary? Is there anything being done to address the specific needs of homeless female veterans that you are aware of?

Mr. GOULD. Ma'am, let me ask Pat Vandenberg to speak to that issue. As you know, we have tremendous focus on making sure that we are building in our capital infrastructure facility suitable for women that has gone directly into one of the Secretary's major initiatives in this area, and of course all of our prevent activities in VHA are focused on avoiding homelessness to begin with for both men and women and then obviously the specific intervention in the U.S. Department of Housing and Urban Development-Veterans Affairs Supportive Housing (HUD–VASH) voucher process and elsewhere is without regard to gender.

Ms. VANDENBERG. Thank you for that question. Dr. Patty Hayes is our VHA lead on looking at all issues pertaining to women's veterans and she has been particularly effective in her outreach efforts to better understand what the unique circumstance of homeless women veterans is, what gives rise to it and she has collaborated extensively with Lisa Pape in the lead looking at how we develop the actual initiatives and outreach to get our veterans, including our women veterans into appropriate housing.

Ms. SÁNCHEZ. Great, and I appreciate that, and I thank the Chairman.

The CHAIRMAN. Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman, I appreciate it and I am sorry arrived a little late. For the plan, I know my colleagues have asked about what happens, does the Department have a plan in the event of a shutdown? I know they have asked about burials, if you can answer that question, disability claims. How about primary care? I know that it will cover, God forbid, an emergency situation, but how about primary care for our veterans? I have a 100,000 veterans in my district.

And also, with regard to the GI Bill, will veterans get their checks, that is my question, to go to school?

The CHAIRMAN. Thank you.

Mr. GOULD. Thank you, sir, and I will let my earlier remarks stand about how much we all want to avert the possibility of a shutdown, but I take your question specifically about your Members. As I mentioned earlier, that primary medical care will be there. We are fortunate enough to have an advanced appropriation

for this fiscal year. What that means practically is that 86 percent of our operations, which are health related, will continue, without interruption because of the advanced appropriation.

And then with respect to your question about the GI Bill, we are still working through the legal aspects of that. We do not have a standard from 1995/1996. As you know, the GI Bill is new, so our lawyers and counsel are working through a proper interpretation of what the impact of that rationale would be on our ability to send checks out.

Mr. BILIRAKIS. One question for Mr. Gould, again. How much of the VA's property would you deem to be excess or underutilized and how long does it take to make the determination that can either be used to meet veterans' needs or solved? And then I do have a couple more if we have time.

Mr. GOULD. Let's see. We have about 830 under utilized buildings now. One-third of those are empty. Two-thirds of them are occupied at 50 percent or below, so a significant number of buildings. That number has dropped in the last 10 years by 30 percent, so we are making progress in that area.

We go through a very detailed process called the BURR, Building Utilization Review and Reports, and I would like Mr. Sullivan, if you are interested in additional detail, to provide some of that for you now. Would you care to have some additional information?

Mr. BILIRAKIS. Definitely.

Mr. GOULD. Thank you.

[The VA subsequently provided the following information:]

> VA had approximately 910 buildings and 10.7 M square feet (Sq Ft) classified as vacant or underutilized as of Feb. 2011. Through disposal, repurposing, or bringing buildings back to full/near full utilization, we have reduced the number of buildings and square footage considered vacant or underutilized by 22 and 28 percent respectively since end of FY 2008.
>
> VA has plans in place to address much of the remaining vacant or underutilized space. Of the current 910 vacant or underutilized buildings, 430 or 47 percent have an identified plan in place for reuse, repurposing, or disposal. These plans will reduce the overall vacant or underutilized square feet to approximately 5.4 M square feet, which is less than 4 percent of VA's owned inventory.
>
> VA has 313 vacant buildings. These buildings have no defined use and are not mission dependent. In contrast, underutilized buildings still provide veteran services, albeit not as efficiently as we would prefer. Of the current 313 vacant buildings, 250 or 80 percent are identified for reuse or disposal. The remaining 63 vacant buildings account for only 697,073 square feet, less than 0.5 percent of the owned VA inventory.
>
> To address the second part of the question regarding timing of actions related to vacant or underutilized buildings, VA utilizes inventory reviews to identify the best options for reusing or disposing of the assets. Efforts such as the Building Utilization Review and Repurposing (BURR) process specifically focus on identifying and assessing suitable vacant and underutilized buildings for reuse opportunities to support homeless housing and other outcomes that provide direct benefits to Veterans or VA operations. If a given building is found to be unsuitable for repurposing, other disposal options are evaluated. Decisions on the proposed disposal or reuse strategy can take from a few months where there is known need and opportunity for reuse, to several months to work through the Historic Preservation and Environmental Compliance requirements if demolition is the proposed strategy.

Mr. BILIRAKIS. Please. Please.

With the economy ever changing and costs fluctuating, how frequently does the VA reassess the feasibility of its priority projects?

How adequately do project cost estimates reflect actual costs? And one more question. How do you believe the bid and acquisition process could be revised to realize greater cost savings on construction projects? How adequately do project cost estimates reflect actual costs? And one more question. How do you believe the bid and acquisition process could be revised to realize greater cost savings on construction projects?

Mr. GOULD. Sir, that is a good list of questions. I hope I caught most of them. This is an annual process, so the beauty of what we have done here is for the first time, if it has three walls and a roof, it is in the SCIP process. It used to be six different processes. Now, it is one. It used to be different criteria. Now, there is a common set of criteria and we do it on an annual basis. How it works is, everybody out to the field, what are the gaps.

Then we apply the standards, run them through, come up with a rigorous prioritized list and then each one of those is required to have a business case associated with it so we can get in there and take a look at the costs and the associated benefit of each of those projects. So you can be assured, your constituents can be assured, that this is a process that we are doing on a rigorous basis annually.

Mr. BILIRAKIS. Since I haven't heard, let us get back again to the shutdown. I asked about the disability claims. Are they covered under the 2-year budget as well, and then burials?

Mr. GOULD. To your first question, there were disability checks provided to individuals in the 1995/1996 experience, and I think that is a fair benchmark for the potential for a shutdown that we all very much would like to avert. And the second area of interest was the burials. Mr. Johnson made a similar observation there. Let me be clear in my response. Burials will continue. What I said was that they would not continue at the level with the sort of customer service orientation, being able to fluctuate, but that we would have to identify an average number and then have people on board to be able to do that.

What that means practically for someone that experiences a death in their family, that called up and were one of the last to call and say I want a burial to occur on Monday, it might have to occur the following day. So, based on the numbers we have, would be some shift in terms of schedule and time, but could they bury their loved one with appropriate last rites and so forth? Of course.

Mr. BILIRAKIS. Okay. Thank you very much. And I may have some additional questions, I would ask you to respond. Thank you so much. I appreciate it.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, sir.

Ms. Brown.

Ms. BROWN. Thank you. Thank you, Chairman Miller and Ranking Member Filner for holding this hearing, coming from Florida with one of the largest elderly populations in the country, we desperately need as much construction as possible.

With the country at war and more and more veterans returning from active duty and from combat, it is ill advised to be closing facilities or trying to balance the budget on the backs of those who have given so much to protect the freedom we hold so dearly.

I have a couple of questions and I don't know whether you have the answers now but, one, I am concerned about the time table of the Jacksonville VA clinic. You can get back with me on that. There has been some problems with the developer and I would like an update on that.

[The VA subsequently provided the following information:]

The timetable was provided in a meeting that occurred on April 26, 2011.

Ms. BROWN. And also, I am pleased to know that the Orlando Medical Center is on track to be completed by next fall after 27 years of working to get this project online. That is just totally unacceptable and the veterans of central Florida deserve more.

But I want to get back to the shutdown and I know it has previously been discussed but I am not completely pleased with the answers or feel that I have gotten the comprehensive answers, based on what I have heard.

When we pass advanced appropriation, I thought that the veterans would be out of the politics of shutdowns and Continuing Resolutions (CRs) and all this foolishness. My question has to do with, not whether the checks would go out, but the processing of the claims of which the backlog we discuss all the time. Will someone be there to process the claims?

Mr. GOULD. Ma'am, first of all, thank you and this Committee and Congress for its foresight in providing an advanced appropriation for VA.

As you just said a moment ago, it really does, I think, fulfill our commitment to veterans when we have the money to be able to do that on a 2-year basis. It has led to, I think, a lot better behavior in terms of the budgeting process and we can now turn to our veterans on the eve of potential shutdown and assure them that with respect to health care, 86 percent of the dollars in the VA budget have already been appropriated for this year, and so that does protect them and pull them out of that situation and all the doubt and angst that is quite rightfully going on right now among our veterans.

So we thank Congress for that advanced appropriation and believe it does address their health care needs for this fiscal year.

Ms. BROWN. What about the pension and other programs?

Mr. GOULD. That is an area where in the past, in 1995/1996, those checks did go out, as I said earlier to the Chairman and the Ranking Member. Our plans are not complete. At VA we have been taking prudent action to update those in the unlikely event that a shutdown occurs.

Ms. BROWN. Not unlikely.

Mr. GOULD. Well, yes, ma'am. I certainly share your hope and view that it doesn't happen, that we can succeed in averting a shutdown. I don't think it serves veterans well to subject them to that uncertainty, but we continue to update and to prepare to take all the precautions that we possibly can to be ready for that possibility.

Ms. BROWN. What about the claims process?

Mr. GOULD. Ma'am, in 1995/1996 the claims process, the checks came out. If you are referring to new claims that come in——

Ms. BROWN. Yes.

Mr. GOULD. Two things happened there in 1995/1996. One is we made sure that under a standard of, called, property rights, that an individual, there is somebody there to stamp the receipt of the claim when it comes in because as you know, the dollars go all the way back to the date they got the claim in. So to preserve their right in that property, we will have somebody there stamping those when they come in.

Now, it is a different matter to actually be moving forward on new claims and those decisions that have not been made yet.

Ms. BROWN. Well, thank you very much. I think my time is almost up, but. I think it is a direct correlation between what we did in December as far as giving billionaires tax cuts and now we are wondering whether or not we have the money for the pension checks for veterans. It is a direct correlation between what we did in December and what is happening here today regarding this government shutdown. Thank you, and I yield back the balance of my time.

The CHAIRMAN. Dr. Roe.

Mr. ROE. Thank you. I don't have many questions, but just a couple of things. One, did you have a plan in 1995 and 1996, or did you just sort of fly by the seat of your pants since most people didn't see it coming?

Mr. GOULD. Sir, we believe, testified, the VA testified in 1995/1996 about the plan that they—and the approach that the Administration took at that time, so there is in the Congressional Record a list of the steps that were taken and it is, I think, a great place to start to answer some of the questions on what might happen in a shutdown.

Mr. ROE. I share your "we don't want to do that" mindset. I think that would be bad. And you said 86 percent, so if a veteran is going to the clinic, they can continue to go to the clinic. Am I correct on that?

Mr. GOULD. Yes, sir. If I heard properly, the hospitals will be open and a person can get that care.

Mr. ROE. And the clinics? And the CBOCs?

Mr. GOULD. And the CBOCs, yes, which is the primary care arm of——

Mr. ROE. Sure. I am a veteran, so if I decide if I need to go to see my appointments next Monday and for some reason if the government shuts down, I can go keep my appointment. That is number one.

Mr. GOULD. Yes, sir.

Mr. ROE. And number two, is that it sounds like that the pension checks and those sources of income are going to continue to flow, that veterans can also be at a veteran's funeral. Certainly, that is a very bad time to have a family concerned about that and we need to allay that concern right this instant. So that continues to happen.

Eighty-six percent of the funds were health care. What is the other 14?

Mr. GOULD. Sir, that would be the other two major administrations within VA, the National Cemetery Administration (NCA) and the Veterans Benefits Administration (VBA). And some of our discussion has gotten to the VBA and the NCA elements.

Mr. ROE. Will research projects that the VA is currently involved in continue to be funded and moved forward?

Mr. GOULD. Sir, I do not believe that R and D is fully covered. There are, of course, the government has a set of investments in making sure that, for example, lab animals have been fed and that no human being would ever be put at risk. I think that, you know, in details of the criteria that are used to decide whether or not and to what extent to shut down R and D, that that would be obviously addressed in the plans that should be in place by Friday of this week, if we have to go there.

Mr. ROE. If we have to go there. Thinking back to the bricks and mortar, there is certainly a need to update your facilities. I like the idea that we have a long range plan and it is debatable on how that is done, but there is no question the VA hospital at Mountain Home where I live is continually being updated and needs to be. You have to do that and you have to have those maintenance funds in there to keep the facilities—and they are constantly changing because the needs of care constantly change. What we can do for people constantly changes.

Mr. GOULD. Sure.

Mr. ROE. So I think that is a good thing. The other thing that I would like to recommend the VA do is look for more partners because in my particular district, for instance, Sevierville, Tennessee, has a hospital they just closed and they opened a brand new $120 million hospital right across the street. They are willing to let the VA use that facility for our CBOC for a dollar a year, and there are plenty of partners like that out there, I think, that would be willing to do that. I believe really want to serve veterans and I would strongly encourage you to look for those partnerships in addition to the things that you currently—and you may be already doing.

Mr. GOULD. Sir, it just underscores the fact that whenever we take a look at medical facilities, health care facilities across the country, 152 major medical centers, typically it is going to be one of the major businesses in that community, certainly one of the top three to five. As a result, it is jobs, it is the physical infrastructure, it is the connection with the community, it is the services the veterans get there. So we want to proceed carefully and we want to proceed with information like that that you have just provided about partnerships and the availability of those as we develop our SCIP plans.

Mr. ROE. Well, to Ms. Brown's comments, I agree completely with her that certainly we do not need to step away from our obligation to our veterans. They don't need to be involved in this. I certainly want to thank the Ranking Member for his support and Mr. Miller, our Chairman, for the advanced appropriations that has made whatever happens this week a lot easier.

The other thing that I want to comment on is the homelessness issue. That is one of the things that I certainly have become very interested in. The fact that we are not getting as many of our HUD vouchers out that we have available and yet don't have housing available is inexcusable. I mean, we had it, but we don't have veterans in the housing. Is there any urgency? I know we are doing a veterans count where I am to try to find out what is the actual

number of homeless veterans. I realize that is a moving target. But we are trying to find that number out so that we know what the need is. I am disappointed when I hear that we have homeless veterans that we have 10,000 HUD vouchers out there that are not being used.

Mr. GOULD. So sir, a couple of months ago I was out doing a homeless count here in Washington, DC, about 8:00 p.m. to 2:00 a.m., I was just struck by how much suffering goes on in the streets in the cities across America. We are making an effort to make sure we have an accurate count for that, and as you can see in the fiscal year 2012 budget, enormous resources are being applied in this area.

Our whole goal is be able to eliminate, to end veterans homelessness by 2015 and we are hard at work on that.

Mr. ROE. Thank you. I yield back.

The CHAIRMAN. Mr. Reyes.

Mr. REYES. Thank you, Mr. Chairman. And I thank you and the Ranking Member for having this hearing and I apologize for being late, but I came from another hearing. I wanted to make sure that I understood what you have testified to here this morning. Has the VA issued guidance for designating essential and non-essential personnel at all of the locations?

Mr. GOULD. No, sir, we have not yet. We still view a shutdown as something that can be averted. We have continued to update our plans continuously over the last months and weeks to try to make that decision-making process, should it be necessary, go smoothly, but we have not issued guidance to the field at this point.

What we are most concerned about is obviously our employees and our veterans. We want to be able to communicate clearly and well with them, should this decision be made, but it has not been made yet and we don't want to color the water with information that we hope is not necessary.

Mr. REYES. When will you be making that decision?

Mr. GOULD. Congress will have a lot to do with that, the negotiations that are ongoing right now. If we do get resolution of that, obviously that would affect our time table. But if there is no action from a budgetary standpoint and the negotiations do not produce either a CR or a bill that gets suspended to the end of the year, then we would be likely to make that communication on Friday, which would be the day of, the midnight Friday, as you know, the end of the continuing resolution.

Mr. REYES. So you will issue guidance during the day Friday, is it on midnight Friday? I ask this question because veterans in my district are very concerned.

Mr. GOULD. Sure. They want to know.

Mr. REYES. And so far there has not been any guidance provided to the local facilities.

Mr. GOULD. That's correct.

Mr. REYES. And I think if you are talking about issuing it on Friday, how can you reassure the Committee that there will be sufficient time to give notice to people that are on vacation, people that are working shift work, all those kinds of things that need to be planned out before executing that plan.

Mr. GOULD. Yes, sir. There are a lot of complexities on this. Fortunately, the law is written in such a way that it allows the Administration the flexibility to affect an orderly shutdown. Our belief is that it can be done in an orderly way and that we do not want to provide additional and unnecessary information and communication that would cloud the central issue, which is our desire to avert a shutdown.

Mr. REYES. So next Monday if there has been chaos in my facility in El Paso—but that is after the fact. Veterans are very concerned right now, and there needs to be some kind of reassurance that the Veterans Administration is on top of this and that the local director will move forward based on your guidance with designating essential and non-essential personnel—I went through this twice when I was in the border patrol, so I can tell you it is a very disruptive situation, and people who get designated non-essential get upset and morale is affected in the local facilities. So there has to be some reassurance from the headquarters, from the national administration, to be able to let people know what is coming, if it comes. We can't wait until Friday to do that, at least I would not recommend that.

Mr. GOULD. As somebody who has been through this process in 1995/1996, served at Treasury at the time, and I was intimately involved with that. It is enormously disruptive.

Mr. REYES. It is.

Mr. GOULD. It has a negative effect on morale. It has a negative effect on the services that we provide to taxpayers. So for many reasons personally I would like to avert a shutdown.

Our management team is on top of the issue. Just a moment ago you said, "Is there some assurance?" Absolutely. I think folks who know Secretary Shinseki know a leader when they see one and who is thinking about the impact on his troops throughout the organization and our veterans.

So absolutely, positively there has been extraordinary care in updating and revisiting our contingency plans for a shutdown. And then finally I would say for your Members who are particularly concerned about health facilities, as I mentioned earlier, the health facilities will be open because we have an advanced appropriation that provides funds for that period.

Mr. REYES. We know that they will be open, but staffing is the issue in terms of designating essential——

Mr. GOULD. All the staff, all the staff will come in, sir.

Mr. REYES. So everybody would be essential?

Mr. GOULD. Yes, sir. And what I mean by advance appropriation for VHA is that all of the—every single one, every single one of the normal operations that go on, the people, the doctors, the nurses, the deliveries, the cleaning, the food and canteen, et cetera, will be done because we have an advanced appropriation and I thank this Committee and Congress for providing, having the foresight to provide that. It really does, as Ms. Brown mentioned earlier, pull our veterans back with respect to their health care knowing that we have a 2-year advanced appropriation.

Mr. REYES. Okay, well, I am going to issue a local reassurance based on what you are telling me here this morning.

Mr. GOULD. Yes, sir.

Mr. REYES. Okay. Thank you.
Mr. GOULD. Yes, sir.
Mr. REYES. Thank you, Mr. Chairman.
Mr. GOULD. Thank you for doing that.
Mr. REYES. Thank you.

The CHAIRMAN. I think I have heard you say that 86 percent of your budget is basically protected. I have heard four or five Members specifically ask you questions regarding a potential shutdown. You are, in my opinion, being secretive and vague. Look, the Committee on House Administration is putting out information today, tomorrow, so that people will know. I mean, certainly people in that 14 percent know that they are in there.

What happens on, I mean, Friday at midnight if the government shuts down, you have 300,000 employees out there, second largest in the country. How do you contact all these people, you know, over the weekend? How does that work?

Mr. GOULD. Very quickly and very carefully, sir. In 1995 and 1996 we did it without essentially email and without the web. Now, we have that. Believe me, we have the attention of all of our employees. They are obviously concerned, nervous, anxious about the lack of certainty in this situation.

And so, the question you are asking me, sir, is how will we communicate to folks. We have a draft strategic communications plan that will make that possible, and we also know that there is certain flexibility in the law that allows for an orderly shutdown, which would include employees coming in on Monday just as they normally do, to sit down with their supervisor and manager and get letters and information that would help explain what has happened, tell them what it is that they need to do and how they need to do it to comply with the law.

The CHAIRMAN. Ms. Buerkle.

Ms. BUERKLE. Thank you, Mr. Chairman. I just have a couple of follow-up questions from the discussion we are having regarding potential shutdown because I am just a little bit confused and maybe you can clarify it for me. I heard my colleague, Dr. Roe, ask specifically if veterans had to be concerned about having access to health care, and if they had a problem, to go in and it would be available. And then I heard you say that the staffing was also included in that advance funding.

So what is the contingency going to do? What are the aspects of the care and all of the veteran services that are at risk here if there is a government shutdown?

Mr. GOULD. Yes, ma'am. You can picture sort of a flowchart that we are required by law to go through. The flowchart starts with the concept of do you have funding. If the answer to that question is yes, a shutdown does not apply. In the case of VHA, we have an advanced appropriation, so every employee conservatively 285,000 of the people who work at VA, will be showing up to work under an advanced appropriation in the same way that they are working today.

Mr. FILNER. Now, that means 40,000 employees won't be?

Mr. GOULD. Now, Mr. Filner, it does not because of the complexities of the law that proceed from there. So you have asked earlier who would be engaged in this very detailed update process——

Mr. FILNER. So it is 30,000? That is a lot of people.

Mr. GOULD [continuing]. That the law requires has a lot of intricacies on this issue. And so we move through a series of decision criteria that get us from, "do you have funding or not," to "is life and property at stake," to "are certain property rights that would otherwise be lost on the part of veterans need to be preserved," and the like. We work through that logic chain to come up with a final number.

So if there was ambiguity in my communication in response to Dr. Roe, about whether our veterans could get health care after a shutdown, I want to eliminate that and remind you that we have an advanced appropriation and that VHA, which is one of the three principal operating units within the VA, will be open for business welcoming our veterans and caring for them for whatever need they have.

Ms. BUERKLE. Thank you. I yield back.

Mr. GOULD. Yes, ma'am.

The CHAIRMAN. If a veteran is listening or watching on the Web today, they have to think this shutdown isn't going to affect them. Basically, your comments today lead this Committee to believe that there is not going to be a negative effect on VA. Is that true?

Mr. GOULD. No, Mr. Chairman. I wouldn't say that.

The CHAIRMAN. Well, would you please give us the negative effects a shutdown would present to VA? You have told us over and over the positive.

Mr. GOULD. Right.

The CHAIRMAN. The 86 percent.

Mr. GOULD. Right.

The CHAIRMAN. Would you tell us the negatives?

Mr. GOULD. Right. So your general question is, will there be negative impacts on veterans? I have given you three illustrations already from the 1995/1996 experience and let me just review them. The first is the Voc Rehab Counseling. Those appointments will not be processed. They will not be ongoing in VA, so our veterans who need assistance in taking on a new career or finding a new job or getting help to seek employment will not be able to have that service if the 1995/1996 guidance stands.

The Board of Veterans' Appeals, case processing and hearing, they are going to be delayed. They were in 1995/1996. We think that there is strong guidance there and, of course, maintenance on our national cemeteries will also come to a halt even though individual burials are likely to continue.

So I realize that it must be frustrating to you for me not to go through chapter and verse. I would say that those decisions are very sensitive. They are the product of long deliberation inside VA and they have not been made yet. They will be made on Friday. Our plan will be finalized on Friday if it is necessary, and my fervent hope is that those plans are not necessary and that we are not in a situation where we have a shutdown.

I am trying to find an appropriate balance between saying that there is no effect, to your comments a moment ago, that is not true, and the reality that with an advanced appropriation, much of what we do will go forward unchanged. And so if I can articulate that

in the right way for this Committee, we have to find that balance in communicating with our veterans not without cost to——

The CHAIRMAN. You said, "much of what you do wouldn't be affected."

Mr. GOULD. Yes.

The CHAIRMAN. So is it fair to say that little of what you do will be negatively affected?

Mr. GOULD. Yes, sir. I think on a dollar basis and an employee basis, that would be a fair conclusion.

The CHAIRMAN. Ms. Brown.

Ms. BROWN. Thank you, Mr. Chairman. First of all, I think you can tell something about an organization, a group, or Congress or whatever how they spend their money, and the decisions that were made in December affect what is happening now. In addition, the fact is, we should have had a year's CR so we didn't have to put the country in this uncertain situation, while we figure out where we want cut or the best way to balance the budget or whatever we are trying to do.

But, you know, we practice what I call reverse Robin Hood around here, robbing from the poor working people and veterans to give tax breaks to the rich. But saying that, let me just say I am still concerned. You've talked about the plan for 1995/1996. This is 2011, and I want to know what plans, what contingency plans do we have because some of the things I am thinking about are homelessness, housing. I mean that is major.

A few weeks ago in Jacksonville, I read in the paper that they discontinued the meals for homeless people. One-third of those are veterans. I called a meeting with the Department of Agriculture to find out what could we do to assist veterans right there in that clutch. I mean, we are making decisions that are affecting the poor people and there is no safety net.

Mr. GOULD. So, ma'am, if there is any veteran that you know of, are aware of or that your constituent office can put us in touch with, we would love to have that contact information, get help to them. The funding for our homeless services in VA has not been affected. In fact, as you know, for our fiscal year 2012, R–10 enacted, it has actually grown, so we are engaged in the work every day of ending veteran homelessness and preventing veteran homelessness.

So if there are veterans out there that we can reach out and help, that is what the taxpayers invested in the VA to do and we would be more than pleased to reach out to those individuals.

Ms. BROWN. I have several of my district staff up here. Maybe we can meet with the VA because I wish it was one name, one person. It is a list. When I pass by my office, the line is wrapped around the buildings trying to get a meal, and it is more than a meal. I mean, the problem, one of the major problems is not just whether or not they get the lunch. It is the fact is they need the mental health counseling. We need to be coordinating with other non-profit agencies to help the veterans, and for some reason we have not been able to make that happen, and so, I mean, whatever we could do.

I wish it was one name. If it was that one name, I would take care of it myself.

Mr. GOULD. Yes, ma'am.

Ms. BROWN. But it is wrapped around the buildings.

Mr. GOULD. That is why we have instigated new programs in VA for homelessness that try to bring all the NGOs, State and local government together into a single service point so that our veterans can enter the building. If the day starts, get a health care checkup, a dental checkup, get a review to see if they have any benefits, get a new set of boots and a jacket, get a meal, get a shower.

So we are focused on trying to create input for our veteran homelessness and would more than welcome the opportunity to have that conversation with you and your staff to deal with this group of veterans.

Ms. BROWN. Thank you. You need to know we want to help.

Mr. GOULD. Yes, ma'am.

Ms. BROWN. I participate in the stand down. I have a job fair that I have over 10,000 people attend that is coming up. I have different groups that will work with the homeless veterans. I mean, I do my part, but it is going to take a team effort, and you know, I commend the Secretary but it just is not one veteran. I wish it was. But the system is not working yet for that veteran that has that problem, that needs that counseling and we just—we can't just do it, VA. It is going to take a coordinated effort between the VA and those non-profits in the community, to give them that support that they need.

Mr. GOULD. Yes, ma'am. I just would add that 2 years ago we were at 131,000 homeless veterans, we are at 76,000 now. We think that number is going in the right direction. At the end of the day, it is about every single individual until there are none of them on the street. That is the goal that we have. That is the goal that we have set to end the homelessness among our veterans.

[The VA subsequently provided the following information:]

Homelessness and coordination with other non-profit agencies was discussed at meeting on April 26, 2011. Ongoing efforts will continue.

Ms. BROWN. My last question, and I love the Secretary, but what is the 2011 plan in case we shut down Friday? Not 1995/1996, I was here then. I want to know what is the plan for 2011.

Mr. GOULD. Yes, ma'am. As I said earlier, we are working on a daily basis to update our contingency plans, working to be as thorough and as careful as we can, but not to encumber the good work of the negotiating teams that is underway right now. It is my hope that we do not shut down government, as I tried to explain here today, largely unaffected with respect to veterans because of the advanced appropriations but not without negative effect. And obviously, I would prefer not to be in a world where we have a shutdown.

So we continue to update that contingency. The Secretary's plan is to approve and finalize on Friday, should it be necessary. And believe me, his staff, myself included, have done the work, are continuing to do the work that will be required to put him in that position to make the decision.

Ms. BROWN. Thank you. Thank you very much. And it is your hope and plan, and it is my prayer. Thank you.

Mr. GOULD. Yes, ma'am.

The CHAIRMAN. Ms. Brown, I will tell you that we will be authoring a letter that I welcome any Member of this Committee to sign on to to the Secretary asking for an immediate brief on what their plan is in regard to the shutdown, potential shutdown.

Mr. REYES. Mr. Chairman, could I——

The CHAIRMAN. We got another Member that has not had a chance to ask their first round of questions.

Mr. REYES. Okay. All right.

The CHAIRMAN. So I would recognize Mr. Stutzman.

Mr. STUTZMAN. Thank you, Mr. Chairman. Mr. Gould, thank you for your willingness to be here and for your testimony. In your witness testimony you emphasize that if veterans and their families do not have access to the VA, they cannot avail themselves of the services and the benefits that they have earned while serving our country. I could not agree more.

In the coming days and weeks, this country will be making some very difficult decisions, that at the same time there are obligations which must be met prudently and honorably. I would add that the accessibility you have emphasized must be convenient and excellent. Could you please share with the Committee the evaluation process for existing facilities like the one in Fort Wayne, Indiana, and the vetting process for proposed improvements there?

Mr. GOULD. Thank you. I would be happy to do that. Just probably to refresh on the process that we use now for all facilities and there are specific issues around Fort Wayne, perhaps we can be responsive to you.

We start with a gap analysis in the field, working to make sure that we have access, the facility conditions themselves, whether there is any additional space, surplus space that might be available in the community. We look at the utilization of those facilities and we also look at the energy needs of the facilities in terms of their condition.

We then take a look at that, vis-à-vis, our standards. We identify a gap. And where there is a gap, we put together a business case and it enters the SCIP process. Once it is in the SCIP process, it goes through a rigorous review against six criteria. Some of those criteria include safety and security, fixing what we have, increasing access, right sizing inventory and so on.

It is then aggregated. The best of the best, the ones that have the highest scores, go before a nine member SCIP panel. Those then are identified—the very top priorities relative to our capacity to pay in terms of the budget—and then it joins the budget process and it is reviewed by me and ultimately by the Secretary before it goes to the Office of Management and Budget (OMB). So it is a very rigorous and thorough process.

If you are interested in some additional specific information about your district, we could perhaps get some help from Mr. Neary who is our expert in this area.

Bob, do you have any additional prospective on the Members' request? Would say again the location?

Mr. STUTZMAN. Fort Wayne.

Mr. GOULD. Fort Wayne. Yes.

Mr. NEARY. Yes, sir. Again, my name is Robert Neary, Acting Director of VA's Office of Construction and Facilities Management.

We have identified a Fort Wayne facility in our authorization request that is in the budget and capital plan volume. When authorized, we would proceed to identify a geographic area within the Fort Wayne area to search for a site, identify a site, acquire a transferrable purchase option on that site, and then compete for a developer, a development team to build and lease back to the VA the facility, likely for 20 years.

Mr. STUTZMAN. Is there a possibility of an existing facility that is already currently built that might be a possibility as well, or are you looking to build a new facility?

Mr. NEARY. In each case we would look to see if there are potentially existing facilities available. It is our experience that on a sizeable clinic such as this, that it's typically better to construct new in order to get the functionality and capabilities and meet energy requirements and that sort of thing, but if there were a facility available in the area, we would look at it.

Mr. STUTZMAN. Okay. And then what about, has the option of a public/private partnership, has that been discussed or thought about with the Fort Wayne facility in particular?

Mr. NEARY. I am not sure about that. We would have to get back to you on that.

Mr. STUTZMAN. Okay. All right. Thank you very much. Mr. Chairman, I just yield back.

[Hon. Joan Evans, Assistant Secretary for Congressional and Legislative Affairs, spoke with Congressman Stutzman on April 25, 2011, and answered his questions.]

The CHAIRMAN. We have one more panel that we have to hear from. Mr. Reyes has asked if he could ask another question. I know the Ranking Member wants to ask. Anybody on our side?

Mr. Reyes.

Mr. REYES. Mr. Chairman, thank you very much. I was going to recommend if you would be willing, in the current proposal for voting on the CR this week, we are funding the Department Defense (DoD) for the year. Would you be amenable for us to send a letter to Chairman Rogers that they might want to include the VA in there because I don't know about your district, but in my district, veterans are very, very concerned about the impact that a shutdown would have on them.

And the second thing is, any cutbacks that might affect veterans. I don't know if you or the Ranking Member——

The CHAIRMAN. The only question that I would have, and I like the idea, obviously we are funded through VA/HUD, the Appropriations Subcommittee. Let me just look at it and just see what it would be.

Mr. Filner.

Mr. FILNER. Just quickly if I may. You threw out the figure, the first I have heard of it, of 76,000 homeless veterans left. I haven't heard that. I would be pretty skeptical that we got it down to that level, but you might give me some backup on how you got to 76,000. That seems very, very low.

Second, I just want to throw an idea for all of you because we tend to separate the facilities from the substance of the health care. Although of course, you state that you must have a good facility to have good health care. I was reminded of that because Mr.

Carnahan was here for a few minutes. There is roughly $500,000 or $400,000 going into renovation at the Cochran Medical Center in St. Louis.

At the same time, you have enormous personnel problems. The hospital is one of the lowest in patient satisfaction in the whole system. I just want to throw out for your thinking, Mr. Under Secretary, that you use not the lever, but the occasion, of new construction and upgrades to say that now is the time to also change the personnel a little bit—to upgrade that.

That is, you just say to the community that we are changing the facility, but we want to make sure that we are also getting in better personnel.

I just throw that out as a way to tell the community we are working on a whole lot of things because it is happening in different places in the country. That is just one I was at and understand better than most. There are a lot of complaints. Why not use the fact that you are going to renovate the personnel structure also?

I know there are all kinds of civil service procedures that you have to take into account, but it seems to be an excellent opportunity to say to the community that we are renovating everything. So just keep that in your thinking if you will.

Thank you, Mr. Chairman.

[The VA subsequently provided a VA News Release, entitled, "VA & HUD Issue First-Ever Report on Homeless Veterans, *Assessment Key to Preventing and Ending Homelessness,"* dated February 10, 2011, which appears on page 58, and a report entitled, "Veteran Homelessness: A Supplemental Report to the 2009 Annual Homeless Assessment Report to Congress," which will be retained in the Committee files.]

Mr. GOULD. Thank you, sir.

The CHAIRMAN. On behalf of the full Committee, thank you for taking time to talk to us today about construction today and in the future, also about things as we look forward to what may happen or may not happen on Friday. We appreciate your being with us today. Thank you. You are excused.

Mr. GOULD. Mr. Chairman, thank you very much for the opportunity to address the Committee on this important issue. Big dollars, but we think great goals, 70 percent access, 95 percent utilization. This is what we are about, taking care of our veterans and I, like you, certainly hope that we can do everything we possibly can to avert a shutdown.

The CHAIRMAN. Thank you.

I would like to go ahead and ask the second panel, if you could, go ahead and approach the table.

Members, we welcome Ms. Lorelei St. James, Acting Director of the Physical Infrastructure Team at GAO and Raymond C. Kelley, Director, National Legislative Service at the Veterans of Foreign Wars of the United States.

Again, each of your written statements will be entered into the record and you will each be recognized for 5 minutes.

Ms. St. James.

STATEMENTS OF LORELEI ST. JAMES, ACTING DIRECTOR, PHYSICAL INFRASTRUCTURE ISSUES, U.S. GOVERNMENT ACCOUNTABILITY OFFICE; AND RAYMOND KELLEY, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED

STATEMENT OF LORELEI ST. JAMES

Ms. ST. JAMES. Chairman Miller, Ranking Member Filner, and Members of the Committee, good afternoon. I am pleased to be here today to talk about GAO's recent work on VA's capital planning efforts.

As you are aware taking care of veterans is a very important mission. VA has thousands of facilities to provide health care and other services to millions of veterans.

Today I will cover two topics. First I will talk about the steps that VA has taken to improve its capital planning process and the challenges it still faces today.

Second, I will talk about the need for VA to provide Congress more information about future project priorities and costs.

As discussed in our January report, for well over a decade, VA has taken three major steps to realign its real property. The first step taken in 1999 was VA's development of the Capital Asset Realignment for Enhanced Services or CARES. CARES was the first long-range assessment of VA's health care priority since 1981. More importantly, it identified changes in real property that VA needed to make in order to close gaps in veterans' care. For example, it recommended that VA close some hospitals and open smaller more accessible clinics. The second step taken in 2004 was VA's development of its 5-year strategic capital plan. In this plan, VA incorporated many leading capital planning practices. For example, it evaluated different alternatives, such as leasing, repairing or building new facilities to meet needs.

VA's third step to improve its planning efforts was taken in 2010. It is VA's new planning process, the Strategic Capital Investment Planning process or SCIP.

Under SCIP, VA ranked and selected capital investments across the organization using weighted criteria and it expanded the 5-year planning horizon to 10 years. We believe these are improvements in VA's capital planning process. Between 2004 and 2009, vacant space owned buildings, vacant buildings, and a number of hospitals was reduced. In addition, in April 2010, VA reported that it had opened 82 of 156 planned community-based outpatient clinics.

However, despite these improvements, challenges remain. For example, in its 5-year plan for fiscal years 2010 through 2015, VA reported a backlog of $9.4 billion in repairs, and 24 of the 69 ongoing major construction projects listed in the plan needed an additional $4.4 billion to complete.

In prior GAO reports and still applicable today, some of the reasons for these challenges include difficulty in getting stakeholders to agree on identified changes and the need for better project cost estimating.

Lastly, VA could provide Congress more information about its future priorities and costs. We feel this is important because VA has identified future project costs in the tens of billions of dollars. Pro-

viding this information, particularly in a long-term fiscal crisis would allow Congress to weigh current budget decisions against future costs. We recommended that VA provide you this information and VA agreed.

In closing, Mr. Chairman, we believe VA has taken steps to improve its planning process. However, it remains to be seen that VA's new planning process will be successful. Its success is critical because VA faces the need for billions of dollars to better meet current and future veterans' needs.

Using a transparent data-driven planning process will help VA better articulate its needs and assist the Congress in weighing the needs of veterans against other critical national needs.

Thank you. I am happy to answer any of your questions.

[The prepared statement of Ms. St. James appears on p. 46.]

The CHAIRMAN. Mr. Kelley.

STATEMENT OF RAYMOND KELLEY

Mr. KELLEY. Thank you, Mr. Chairman. On behalf of the 2.1 million members of the Veterans of Foreign Wars, thank you for inviting me to testify today.

Without adequate and accessible treatment facilities, delivery of care will be compromised. This hearing is the first step to ensuring that veterans not only receive the best care but also receive the care in a location and in a facility that best meets their needs.

Strategic Capital Investment Plan (SCIP) has identified 4,808 capital projects, with a price tag that ranges between $53 billion and $65 billion. All of these projects will need to be completed to close condition, utilization, access, and space in gaps.

Currently, all VISNs have at least $100 million in D and F rated Facility Condition Assessments gaps with nine having over half a billion dollars in gaps. This occurred because of years of under funding for non-recurring maintenance.

Inpatient utilization in 9 VISNs will increase over the next 10 years. Outpatient demand will increase in all 21 VISNs in that same period. VA has well thought out plans to build new and reuse existing space where appropriate, lease when available, and demolish and mothball when necessary. VFW supports VA's Utilization Gap Reduction Plan, but we believe too much of the financial burden is being pushed to out years.

Currently, 7 VISNs are not meeting the 70 percent of the enrollees residing within the VA's drive-time goal. VFW supports VA's accessibility gap reduction plan.

VA's space inventory is at a deficit at 12 of the 21 VISNs, and VHA as a whole will reach 125 percent capacity within the next few years.

VA is aggressively repurposing or removing many of its underutilized or vacant buildings. Although VFW recognizes the need for the removal of buildings, we ask that VA provide more information on that decision process. Overall, VFW believes VA's gap analysis for future usage and property management is acceptable.

Enhance Use Lease is due to expire at the end of this calendar year. Without reauthorization, VA's homelessness initiative will be jeopardized. It is vital that this program be reauthorized. Since

2006, $266 million has been saved through VA because of this program. Please reauthorize this program.

VFW believes that 2012 budget request is extremely low. Investing $2.88 billion annually for an overall capital infrastructure budget will not meet the needs of these growing gaps. VA is admittedly back-loading the capital plan by placing more than $16 billion in minor construction and NRM needs in the years 2017 through 2021. VA cannot continue to push current needs to out-years. Buildings will only continue to deteriorate and the capital investment plan will only grow its deficit. VFW believes that the VA's major construction account should be funded at $1.85 billion, not the Administration's requested level of $590 million. This will allow them to complete all current, partially funded projects within 5 years, begin providing funding for 15 new projects, and complete all currently funded seismic corrections within 3 years. In the fiscal year 2010, NRM received a total of $2.1 billion. VA is requesting only $871 million in the next fiscal year.

Slight increases in the 2012 budget request will allow VA to easily eliminate minor construction gaps over the next 10 years, and the leasing appears to be on track to close all those related gaps in that same time period.

In closing, VFW is impressed with VA's gap analysis and their process of determining corrective actions for all identified gaps. However, VFW would like to see more information on the building disposal process, as well as requests for funding that will set VA's capital plan in the right trajectory.

VFW also requests that this Committee and Congress as a whole take a serious look at the long-term effects of not having a viable capital infrastructure for VA. Partnerships with medical universities will fade, training and recruitment of doctors will diminish, and vital research, which has been a tremendous recruitment tool for VA, will not be productive. Reducing VA's capital infrastructure spending will have second and third order of effects that will cost taxpayers more in the long-term. There is no short-term fix to the VA's infrastructure problem, so we must stop looking for one and begin funding VA construction at an appropriate level and set VA on a path of correcting gaps so current and future veterans will receive the care they earned and deserve.

Mr. Chairman, this concludes my testimony, and I look forward to any questions that the Committee may have.

[The prepared statement of Mr. Kelley appears on p. 49.]

The CHAIRMAN. Thank you, Mr. Kelley.

Ms. St. James, you have heard some discussion here with the previous panel about basing investment decisions today on projections in 2018. What is your view on that type of projection?

Ms. ST. JAMES. In leading practices, projecting out 5 to 10 years is a good thing. What VA has to be able to do is note that in its projections are estimates and that as each year progresses further to the beginning of projects, those estimates get better. That was one reason we recommended that VA in their future budget submission, include the full results of SCIP so that you can see the priorities and the total cost that they are looking at in the future years.

The CHAIRMAN. But they did not add activation and operation costs and so, you know, you have heard that asked as well.

Ms. ST. JAMES. Correct.

The CHAIRMAN. So how serious a problem is it in SCIP that they don't include those numbers?

Ms. ST. JAMES. Because our report was issued before VA implemented SCIP, the way that the timing was reported, we were not able to look at SCIP per se, but we did note in preparing for the testimony that VA is planning to provide those activation costs and operating costs into SCIP. We think that is a good idea.

The CHAIRMAN. Do you know when they are planning to provide those costs? Because I tried to get them just a minute ago and I couldn't get any.

Ms. ST. JAMES. Not at this time. We don't know.

The CHAIRMAN. Mr. Kelley, would you be opposed to a third party independent group taking a look at SCIP and just having a new set of eyes just to validate VA's findings?

Mr. KELLEY. If Congress is willing to fund a program to put another set eyes of it, then it can't hurt anything. But you can't expect VA to do more with less. So if you are asking them to go out and find a third party to review what they have done, you must also account for the funding that it is going to cost to do that.

The CHAIRMAN. So if it is funded, you don't have a problem with a third party?

Mr. KELLEY. Absolutely. Oversight is the best thing going.

The CHAIRMAN. Ms. St. James, one other question. What other actions can VA consider to ensure better management of their real estate portfolio?

Ms. ST. JAMES. GAO has been looking at this topic for decades and we have made a number of recommendations. For example, in 2010 we made some recommendations to VA to improve their cost risk analysis as well as doing an integrated construction schedule and doing a schedule risk analysis.

And we are following up with VA, so there are some things that we recommended in the past that we will go back and we follow up with them to do. I think in the long run as VA looks at SCIP, the key thing is linkage. Are they measuring what needs to be done? Are they linking their capital facilities to what they agree to in their strategic plan and is it necessary to do?

The CHAIRMAN. Do you know which of those suggestions the GAO made to VA were implemented?

Ms. ST. JAMES. We checked back just recently with them on the risk analysis that I mentioned and we understand that they are partially implemented, so we are continuing to follow up for our own records what that really translates to.

The CHAIRMAN. For the record, would you report back to the Committee what you find?

Ms. ST. JAMES. Absolutely.

[Ms. St. James subsequently followed up in a letter to the Chairman, dated April 20, 2011, which appears on p. 59.]

The CHAIRMAN. Ms. Brown.

Ms. BROWN. Thank you, Mr. Chairman. You know, in December when we gave those tax cuts, over $700 billion. Now we are struggling with how are we going to pay the bills for our veterans. And

Mr. Kelley, let me just ask you a question because in reviewing *The Independent Budget,* it supports levels for minor and major construction as well as way above the President's recommended budget. Based on the climate and shared sacrifices, please expand your rationale for these recommendations.

Mr. KELLEY. In the budgets, *The Independent Budget's* recommendations?

Ms. BROWN. Yes. Uh-huh.

Mr. KELLEY. We made a sacred promise to veterans that we will provide them care.

Ms. BROWN. Uh-huh.

Mr. KELLEY. To facilitate that care, you have to provide it in a facility. You can't have one without the other. So you have to fund facilities and infrastructure to be able to provide that care, so it is a top priority. Without infrastructure you will not be able to provide the service that you have promised veterans.

Ms. BROWN. So giving the climate that we have here and the basic billions of dollars that we gave away in December, how do you think we are going to do that? They say everybody needs to get in the tank. I think the veterans have already been in the tank.

Mr. KELLEY. I agree. There is always cost savings. We, as *The Independent Budget* and some other organizations are working now to work on finding areas where there are some efficiencies that can be found and we will be happy to report those back to you to help find offsets, but what our recommendation will also state in that is that that money be reinvested back into the veterans, that that is money not to be saved but to be reinvested for veterans.

Ms. BROWN. So you are saying that you don't think it should go for deficit reduction?

Mr. KELLEY. Veterans are not getting what they have been promised at this point. So any money that is being spent within VA that we can find an efficiency on needs to be reinvested to make sure that we fulfill that promise. Yes. So, no, do not send that money back for deficit reduction.

Ms. BROWN. So that would not be the priorities of *The Independent Budget* to take your savings and put it in deficit reduction?

Mr. KELLEY. That is correct.

Ms. BROWN. Okay. Well, that is my position, too. What extent does SCIP, Ms. James, equip VA to address the current backlog of maintenance approximately $9.4 billion, as reported in the VA 5-year capital plan for fiscal year 2010 and 2015?

Ms. ST. JAMES. There are a couple of things that we think that VA is doing through SCIP that are leading best practices and that was talked this morning, and one of them is taking a centralized view of all of your projects, not just within, you know, each separate administration within VA. So that gives more oversight and a chance to equally balance what needs to be done throughout the organization.

It also put a cost for all major, minor, non-recurring and leases. So you need to have that information to be able to make centralized decisions, so we thought that was good.

We have not verified SCIP. They were just applying to the 2012 budget, so we see some good leading practices, but we couldn't

come out and tell you how effective it is because it simply wasn't being used at that time we did the report.

Ms. BROWN. Does the VA work very closely with the local entities, for example, someone mentioned it earlier and I know, that in certain communities, particularly in the rural areas, some of the hospitals are closing. Is it possible that VA could have some kind of a partnership, so we could have some kind of cost sharing to provide services to those veterans that are not in an area that they are close to a hospital?

Mr. KELLEY. VA, again, that is part of the Enhanced Use Lease that needs to be reauthorized. VA is looking at well over 100 properties right now that they would like to use that for and they range anything from homelessness to shared properties for medical treatment, so yes, we support that and VA supports that.

Ms. BROWN. All right, Mr. Chairman. Thank you. I yield back the balance of my time.

The CHAIRMAN. Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman. I appreciate it. I have a question for Ms. St. James. Do you believe that the VA's current system of evaluating construction priorities is effectively ranking feasible projections with respect to long-term costs. And then also, could you elaborate on when you think it can be done to best estimate actual costs?

Ms. ST. JAMES. In long-term planning, the costs are going to be just that. They are going to be estimates and VA's process of prioritizing, if that is what you are asking about, they, as was indicated this morning, they are using six criteria. The first being safety and security, and then there is linkage to the strategic plan and then taking care of what they have, and that represents 74 percent of, you know, their emphasis on what they are trying to do with those top three things.

And in the cost estimating piece, if you look at how VA plans, based upon models that tell them they need certain facilities and procedures in very well laid-out guidelines from OMB, as well as from our work at GAO is done, this is how cost estimates should be done. And part of what I was talking about earlier is that we have made some recommendations to better improve their costs estimates, so that's part of what we could get back to you on what VA has done in regards to those recommendations.

Mr. BILIRAKIS. Okay. Very good. Thank you. Thank you. I yield back, Mr. Chairman.

The CHAIRMAN. Dr. Roe.

Mr. ROE. Just very briefly. How many veterans do we serve in the country now? How many veterans that are actually signed up? Do you have that number?

Mr. KELLEY. I believe it is around 6 million.

Mr. ROE. About six—okay. I helped develop so many offices and design them and then two or three hospitals now in the local community. I understand that it is not easy to get down range and find out how much your need is going to be. It is like building a house. You never put enough closets in it. That is what you find out. You always need three more.

So when you design a building or try to estimate what those needs are going to be down the road, it is hard. There is no ques-

tion about it. And you never have enough money. So I do like the idea that the VA has some criteria because you never get enough money to build everything you want. I mean, you have to go with what you can afford, so I appreciate that and I am glad there is objective criteria out there to try to do that. The needs will be greater somewhere else.

But Mr. Kelley, you made the—I want you to repeat this because it may be in your written testimony, about what you thought the needs were now that maybe I misunderstood when I was listening.

Mr. KELLEY. The needs for funding?

Mr. ROE. Yeah, right now. I mean, you were a little short about how much you said.

Mr. KELLEY. Right. VA for major construction is asking for $590 million, for major construction alone. *The Independent Budget* had recommended $1.85 billion for major construction, and that puts us on a track to complete everything that is already implemented within 5 years, start 15 new projects and all seismic deficiencies that have already been started, have them completed within 3 years.

Mr. ROE. Okay. That is what I wanted to know. I think, looking down the road, you have to estimate how many veterans you will serve, 5, 10 and 15 and 20 years from now, and that isn't easy. Military is different now because it is volunteer and when I was in, we were all drafted. Because most of us were drafted, there were larger numbers of veterans to cover.

Now, what you have, it looks to me like the intensity of the service is much greater because many of these veterans are going, being deployed 2, 3, 5, 6 times, but it is the same people going over. Whereas, when I was in, there were different people going back to Vietnam. So I think finding out what you perceive the need to be later on down the road is important to us as far as facility structures.

You don't want to build a bunch of structures and then have them empty. For instance, a 100-bed hospital now or 200-bed hospital, 500-bed hospital could because of length of stays, because of how the technology has improved and how much of it is done as an outpatient. So I think all of that going forward is important when you look at just facilities. It is not just bricks and mortar. That is the cheap stuff really. It is really the ongoing costs of the personnel later on down the road is important, I think.

And I know you all have probably done that. I like the process. Ms. St. James, any comments?

Ms. ST. JAMES. I would agree with what you said and I think when it comes to the planning process, whether it is personnel or bricks and mortar or the X-ray machine, whatever equipment goes along, they are all instruments in carrying out the mission of the VA, and although it sounds simple to do, to realign and align all of your resources in towards that mission, it is difficult. It is difficult to do.

Mr. ROE. Thank you. I yield back.

The CHAIRMAN. Any other questions from the Committee? Thank you for sitting for a couple of hours waiting to come forward and testify, both of you. We appreciate your willingness to be here today. I would say that all Members would have 5 legislative days

to revise and extend their remarks. Any other comments for the good of the order?

Without objection, this hearing is adjourned.

[Whereupon the 12:34 p.m. the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Hon. Jeff Miller, Chairman, Full Committee on Veterans' Affairs

Good morning. This hearing will come to order.

Before we begin, I ask that everyone please take a moment of silence for former Representative John Adler, a distinguished Member of this Committee during the 111th Congress, who passed away yesterday.

He devoted his life to helping others through his service to our Nation. John took his role on this Committee very seriously and was an advocate for veteran-owned businesses as well as helping to cut the red tape to improve the VA claims process. Let us keep the Adler family in our thoughts and prayers.

Before we proceed with today's hearing, I would like to take care of one item of Committee business by adopting a resolution filling our full Committee roster for the 112th Congress.

The list is before the Members and I ask Mr. Bilirakis for a motion on this resolution.

[Adoption of resolution]

I thank the Ranking Member and the staff for working with us to fill the vacancies. That concludes our business meeting and I would now turn the Committee's attention to today's scheduled hearing.

I want to welcome everyone to today's hearing titled: "Deconstructing the Department of Veterans Affairs (VA) Construction Planning."

We are here to examine VA's FY 2012 construction budget request, including the methodology used to arrive at the request, and VA's long-term construction outlook. Unlike previous long-term construction modeling that covered 5-year projections, VA has now put forth a 10-year construction plan using the Strategic Capital Investment Planning, or SCIP ("skip"), process.

The SCIP process is intended to draw upon past lessons in VA construction modeling as well as knowledge from the private sector in meeting current needs and anticipating future ones.

Without a doubt, a new capital asset planning process presents new challenges and opportunities. The opportunities are there to provide veterans with state-of-the art health care in modern facilities closer to where veterans live.

The challenges are that VA has an aging hospital infrastructure, a considerable backlog of maintenance projects, an aging veteran population that makes long-term planning difficult, and a constrained fiscal environment within which to operate.

VA's SCIP plan has been described as a 10-year "action plan" that would require a minimum investment of $53 to $65 billion over 10 years.

Needless to say, given the fiscal environment we are in, that is an ambitious funding requirement, one that we must be sure relies on good assumptions and reliable analyses. Toward that end, I have several questions I'd like to examine at this hearing.

First, I'm interested to learn the health care utilization assumptions that were used in adopting the plan, especially given the expected dramatic decline in the veterans' population over the next 20 to 30 years.

Second, I'm interested to learn whether the $53 to $65 billion price tag can realistically be met given that the President's FY 2012 request, if carried forward annually for 10 years, would only meet roughly half the total cost.

Third, I'm interested in learning about the alternatives VA considered to meet its service delivery needs other than in-house construction. Were partnerships with other Federal providers adequately explored? What about public-private partnerships?

In short, were all available options to meet veterans' needs on the table and fully considered?

Fourth, it is my understanding that the SCIP plan does *not* include costs associated with up-front facility activations, or annual operating expenses. I'm interested to learn whether those costs ought to be known before Congress adopts one proposal over another.

Finally, I'm interested in learning about VA's recent performance in its management of construction projects. If the Committee can be given some assurances that VA has been a good steward of the construction funding Congress has already provided, it will help in the decisions we must make moving forward.

I believe it is imperative that VA use full transparency in presenting its decision-making process and how every dollar is spent once appropriated.

VA must also ensure that all cost-effective options are considered, all bias acknowledged, and due diligence conducted as it moves forward in its capital asset planning.

Comprehensive planning on the front end will prevent massive cost overruns and project delays down the road.

In the end, our overarching objective is clear. Veterans expect, and we should deliver, the best that 21st Century health care has to offer.

This hearing begins a discussion of how we will collectively chart a path toward meeting that objective.

I appreciate everyone's attendance at this hearing, and now yield to the Ranking Member for an opening statement.

Prepared Statement of Hon. Bob Filner, Ranking Democratic Member, Full Committee on Veterans' Affairs

Good morning everyone, and thank you, Mr. Chairman, for holding this important hearing on the capital planning and budgeting process for the Department of Veterans Affairs.

VA is the owner and operator of 33,000 acres of land and over 5,500 buildings. Many of the VA hospitals and medical facilities are aging and are in need of major renovation or replacement. Many VA facilities need to be upgraded in order to meet standards for earthquakes, fires and patient privacy.

Central to VA's mission is the operation and delivery of the highest quality health care to our Nation's veterans—and we understand that a key part of this care is the facilities in which it is provided.

The VA's fiscal year 2012 budget included the Department's 10-year Action Plan and according to VA—the plan is a living document reflecting changes in the composition and alignment of assets. It represents a snapshot in time based on the current state of VA's capital portfolio and projected needs.

This 10-year action plan comes on the heels of the Capital Asset Realignment for Enhanced Services or CARES. I am sure we all remember the CARES initiative which was the first comprehensive look at VA's infrastructure and alignment since 1981.

In 1999, VA initiated the CARES process, along with a 5-year capital plan for the Department's construction budget. When the VA embarked on the CARES process, the VA's health infrastructure was thought to be unresponsive to the needs of current and future veterans.

While about 24 percent of the veteran population was enrolled in the VA for health care, the CARES plan assumed that the enrollment population would increase to 33 percent by the end of 2022. In addition, there were concerns about the ability of the existing health infrastructure to meet the demands of the aging veteran population who opt for warmer climates in the South and the Southwest.

CARES was intended to eliminate or downsize underused facilities, convert older massive hospitals to more efficient clinics, and build hospitals where they are needed in more populated areas.

In essence, CARES was to direct resources in a sensible way to increase access to care for many veterans and to improve the efficiency of health care operations across VA facilities. VA informed this Committee in order to implement CARES properly they would need $1 billion dollars a year for 5 years.

Because of the delays in the process, many of the identified projects rose in cost which ended up costing much more than original projections.

CARES was supposed to be a blueprint for future VA facilities development. However, here we are, once again, looking at a new process implemented by VA in the fiscal year 2012 budget. This year, the VA rolled out the Strategic Capital Investment Planning (SCIP) program designed to build upon the CARES process.

With this new process and 10-year look, that includes pending CARES projects, VA's projected construction needs are between $53 and $65 billion. However, if you do the math for the present rate of FY 2012 request of $2.8 billion, it would take 20 years to meet the minimum resource need identified in the 10-year plan.

It is unclear to me how VA will continue to follow this, and it is also unclear how well SCIP will address the medical and demographic needs of current and future veterans of Afghanistan and Iraq.

We look forward to working with the VA to ensure that our veterans receive the best possible care in medical facilities that are modern and safe—while being built efficiently and cost-effectively.

I look forward to hearing about the current construction process, VA's plans and needs for future construction, and how this Member can support this effort—with the end goal always being to provide the best possible health care to our veterans.

Mr. Chairman, I yield back.

Prepared Statement of Hon. Silvestre Reyes

Thank you, Chairman Miller and Ranking Member Filner, for calling this hearing to discuss the VA's construction planning. It is clear that many VA facilities are old and outdated. So even in a constrained budget environment, it is imperative that we continue to update, and where necessary, replace VA medical facilities.

In addition to rehabilitating existing VA health care facilities, it is essential that we find a way to make veterans health care more accessible. There are many ways to provide health services to America's veterans. Secretary Shinseki stated before this Member earlier this year that his fiscal year 2012 budget request includes more than $108 million for the Veterans Relationship Management (VRM) program and $70 million for the Virtual Lifetime Electronic Record (VLER) program. While these are great leaps forward in providing access to veterans, there is no substitute to having a local medical facility.

I want to commend the Veterans Administration in their implementation of the 10-year Strategic Capital Investment Plan. By looking twice as far into the future than the previous CARE plan, it will enable the VA to more effectively provide medical services across the country. With the growing number of Iraq and Afghanistan veterans returning with persistent wounds like traumatic brain injury and post-traumatic stress disorder, it is imperative that we ensure they have continued access to medical care regardless of where they call home.

I know it is the goal of every Member of this Member that we ensure every veteran has access to health care. I thank you again for your work, and I hope that, by working together with your organizations, we can continue efforts to ensure that no American Veteran is left without the care and support they deserve.

Prepared Statement of Hon. W. Scott Gould, Deputy Secretary, U.S. Department of Veterans Affairs

Chairman Miller, Ranking Member Filner and distinguished Members of the Committee, thank you for the opportunity to appear today to discuss the Department of Veterans Affairs (VA) construction priorities and planning. Joining me today are: Mr. Glenn Haggstrom, Executive Director, Office of Acquisition, Logistics and Construction (OALC); Mr. James Sullivan, Director, Office of Asset Enterprise Management, Office of Management; and Ms. Patricia Vandenberg, Assistant Deputy Under Secretary for Policy and Planning with the Veterans Health Administration.

It is an honor and privilege for me to represent Secretary Shinseki and the many dedicated, hard-working professionals of the Department who support our mission to serve Veterans and their families by providing benefits and world class medical services.

VA's top three priorities are to increase access to services and benefits for Veterans, eliminate the claims backlog, and end Veteran homelessness. While addressing these priorities it is also imperative that we ensure our employees and our Veterans are provided safe and secure facilities in which to work and receive care and benefit services. These priorities are the principal drivers of our planning for VA's infrastructure.

With regard to access, this is a priority of the first order. Simply put, if Veterans and their families do not have access to the VA, then they cannot avail themselves of the services and benefits that they have earned while serving our country. Access

to our benefits and services depends on three things: the scope of and breadth of programs, technology avenues, and the physical facilities in which we operate. This last point, physical facilities, is critical to access in our health care and cemetery systems.

One of Secretary Shinseki's first actions was to declare the need to eliminate homelessness among our Nation's Veterans. Since 2008 we have reduced the number of homeless Veterans living on the streets on any given night from 131,000 to 76,000. We are proud of this early success, but we have a long way to go and we will need all possible tools at our disposal to make this vision a reality. The Department has a number of critical tools or programs available at its disposal that assist in eliminating Veteran homelessness by leveraging current VA infrastructure to provide housing to our homeless Veterans and their families. These programs include the Enhanced-Use Lease (EUL) authority and the Building Utilization Review and Repurposing (BURR) program, both of which I will provide more details on further in my testimony.

As I mentioned earlier, the safety and security of our Veterans and employees is paramount. While we are increasing access, eliminating homelessness, and implementing our other priorities and initiatives we must never lose sight of the importance of providing a safe and secure environment at our VA facilities across the country.

To understand what we will need to achieve these priorities we must look beyond the annual budget cycle and determine the investments needed to meet our projected long term requirements. In the areas of capital investment, the recently unveiled Strategic Capital Investment Planning (SCIP) process accomplishes this by determining our current state and projecting our needs 10 years into the future to determine what infrastructure gaps must be addressed in order for the VA to provide adequate access to Veterans, ensure the safety and security of Veterans and our employees, and leverage current physical resources to eliminate homelessness among Veterans.

But while we are working toward achieving these priorities we must also ensure the efficient and effective use of taxpayer's dollars. While looking a decade into the future, SCIP prioritizes the capital needs across VA's three Administrations (VHA, VBA and NCA) as well as across the programs from which capital funding is provided (major construction, minor construction, non-recurring maintenance and leases). No longer are VA capital decisions made in Administration or program stovepipes. By taking a "corporate" approach to capital planning, SCIP ensures that our capital investments for all Veteran needs across the country are considered together and are prioritized according to the same criteria.

It is also important to note that providing needed infrastructure improvements also adds the benefit of creating competitively awarded short-term construction jobs as well as long-term health care and service delivery employment opportunities in local communities throughout the Nation.

The remainder of my testimony will address the Committee specific request that VA testify on gap analysis as it relates to current and future demand; underutilized or vacant property; how VA evaluates and considers alternatives to planned investments; cost analysis and risk assessment; prioritization of new projects and renovations; the basis for the fiscal year 2012 construction authorization budget request; and the viability of the 10-year capital plan. I welcome the opportunity to discuss these important issues and address any concerns the Committee may have on these topics.

The Basis for the Fiscal Year 2012 Construction Authorization Budget Request

A little over 6 weeks ago, Secretary Shinseki delivered the President's 2012 Budget to this Committee. Some of my testimony may repeat information the Secretary shared with you at that time, and much of this information can be found in Volume 4 of the Department's 2012 Budget Submission—"Construction and 10 Year Capital Plan." This budget volume communicates VA's capital investment needs spanning a 10-year planning horizon—beginning with the 2012 budget—and discusses how the SCIP process was used in the development of the 2012 construction budget submission.

My desired outcome for the brief time spent with you today is to provide depth and meaning to the numbers and information on SCIP, and to provide insights on how all the pieces fit together. Equally important, I will highlight some additional innovative strategies and tools VA is using across the Department's portfolio of capital assets to maximize, repurpose, and right-size our inventory. Our strategic capital approach is part of our Integrated Operating Model which is designed to strengthen our management infrastructure across VA. These tools further support

our commitment to VA's strategic priorities such as ending Veteran homelessness, and meeting our obligations to all Veterans in an effective, accountable, and efficient manner.

For 2012, VA is requesting more than $2.8 billion for major, minor, non-recurring maintenance and leasing programs. New budget authority of $1.27 billion is for VA's construction programs: $589.6 million for major construction and $550.1 million for minor construction, and $131 million for grants. VA also plans to apply an additional $135.7 million that have been previously appropriated by Congress to 2012 major construction projects. In addition to major and minor construction programs, the Department is requesting $868.9 million to fund the medical facilities' non recurring maintenance account, and an additional $834 million for 2012 leasing activities.

VA's 2012 construction request reflects a continued commitment to provide Veterans with quality health care and benefits in modern, safe, and secure facilities. The request includes seven ongoing major medical facility projects (New Orleans, Denver, San Juan, St. Louis, Palo Alto, Bay Pines, and Seattle) and design for three new projects (Reno, West Los Angeles and San Francisco). One cemetery expansion project will be completed to maintain and improve burial service in Honolulu, Hawaii. The 2012 request would also fund needed alterations, improvements and renovations of existing hospitals, community based outpatient clinics, expansion of national cemeteries and enhancements of other VA facilities such as Vet Centers and regional offices.

2012 Authorization for Major Medical Facility Construction/Leasing Projects

In addition to the 2012 budget request, VA is required to obtain authorization for medical facility investments classified as major construction as well as for those medical facility leases with annual rent of over $1 million. Based on the 2012 SCIP process, VA plans to submit a legislative request to authorize seven (7) major medical facility projects as follows: Construct a clinical addition and a parking garage in Fayetteville, Arkansas; add a Simulation, Learning, Education and Research Network Center to the previously authorized new medical facility project in Orlando, Florida; construct an Ambulatory Care, Polytrauma and Blind Rehabilitation Center in Palo Alto, California; Medical Facility Improvements; expand the National Cemetery at St. Louis (Jefferson Barracks), Missouri; and to seismically correct three buildings at three medical facilities: Building 1 in San Juan, Puerto Rico, Building 100 in Seattle, Washington, and Building 209 in West Los Angeles, California.

In addition to these major medical facility construction projects, VA plans to seek authorization for major medical facility leases for five Outpatient Clinics and three Community Based Outpatient Clinics. The Outpatient Clinics are located in Fort Wayne, Indiana; Mobile, Alabama; Rochester, New York; San Jose, California; and South Bend, Indiana. Three Community Based Outpatient Clinics require authorization: Columbus, Georgia; Salem, Oregon and Springfield, Missouri.

Overview Strategic Capital Investment Planning (SCIP)

In developing the 2012 budget, with the initiation of SCIP, VA made far-reaching enhancements to its strategic capital planning and investment decision-making processes by providing a more comprehensive approach to capital investment planning. SCIP builds upon previous capital investment processes by capturing, for the first time, the full extent of our infrastructure inventory (including underutilized and vacant properties), identifying gaps in the provision of service to our Veterans and their families, and developing a 10-year strategic capital plan, employing both capital and non-capital solutions, to address these gaps.

This transformative tool enables VA to deliver the highest quality services by targeting investments now and into the future that balance and prioritize competing interests and address our most critical needs first. VA's first-ever Department-wide integrated and prioritized list of 2012 capital projects is an important outcome of the SCIP process. Through SCIP, VA evaluates each capital investment proposal based on its contribution to six key criteria—the most important of which is "Safety and Security". The remaining five criteria are, "Department Major Initiatives," "Fixes What We Have," "Increases Access," "Right-Sizing Inventory," and "Ensuring Value of Investment."

SCIP's Data Driven Approach to Identify Gaps

As an integral part of the SCIP process, VA systematically identified performance gaps where current infrastructure or services need to be enhanced to meet the location and demand of current and future Veterans. Guidelines provided to the Administrations required capital investments to contribute to correcting corporately-identified gaps in access, utilization, space, condition, energy, safety, security, parking de-

ficiencies, IT deficiencies, as well as other functional deficiencies such as privacy and emergency preparedness for each investment proposal.

VA faces major challenges with its aging infrastructure. On average, VA buildings are more than 60 years old. The SCIP process directly addresses these challenges with a range of solutions, including reuse or repurposing, and working with State and local historical societies to identify properties that should be demolished. These efforts increase efficiencies and decrease the government spatial footprint.

Evaluation and Consideration of Alternatives to Planned Investments

A business case was required to accompany each 2012 investment proposal. Each business case included the following components: Project description and justification; a quantification of the performance gaps the project would address; the alternatives considered; and, the impact the project would have on meeting the Department's strategic initiatives to better serve Veterans.

The business cases were also required to include alternative options to the investment proposal. Major construction and lease projects were required to provide an "alternatives analysis" that considered the status quo, new construction and/or renovation, leasing, and contracting out for services. Minor construction and non-recurring maintenance projects were required to provide an analysis of the status quo and two additional options.

Cost Analysis and Risk Assessment

All business cases also included a cost-effectiveness analysis (CEA) that compared the costs of the status quo to the other alternatives considered. A portion of each project's total score was based upon whether it provides the best value compared to the proposed alternatives. Major construction and leases greater than $1 million in annual rent that are selected for inclusion in the budget request are required to complete OMB's Exhibit 300s. These exhibits provide a more comprehensive analysis of the alternatives considered, cost effectiveness assessments, risk analysis and risk management plans.

Building Utilization Review and Repurposing

To best utilize resources and sustain our commitment to good stewardship, SCIP requires that existing capital assets be considered for reuse or repurposing. SCIP identifies the underutilized and vacant properties and the Building Utilization Review and Repurposing (BURR) program identifies potential strategies for their reuse or disposal. VA has reduced its inventory of owned vacant space by 34 percent, from 8.6 million square feet in 2001 to 5.7 million square feet in 2010. It is anticipated that the BURR process will put a significant number of buildings in use to serve our homeless Veterans and their families.

The BURR process will assess the potential to develop new housing opportunities for homeless or at-risk Veterans and their families for use in public-private partnerships and VA's enhanced-use lease (EUL) program. The Department's EUL authority allows VA to match supply (available buildings and land) and demand among Veterans for housing with third-party development, financing, and supportive services. This approach has multiple benefits: helping to reduce homelessness among our Veterans while leveraging an underutilized asset, reducing the inventory of underutilized real estate, and transferring the operation and maintenance costs to a developer. Other internal and external potential reuse opportunities will be explored for buildings determined unsuitable for housing. Currently, the Department's authority to enter into additional EUL agreements expires as of December 31, 2011. The Administration will be submitting a legislative proposal to address this expiration.

Viability of the 10–Year Capital Plan

The 2012 SCIP process identified an estimated cost of $53–$65 billion to close all currently-identified gaps over the next 10 years. The advantage to the SCIP-based 10-year strategic capital plan is its data-driven approach in which all projects are prioritized based on identified needs and the ability to close known performance gaps. The SCIP process is dynamic and will require an annual update as part of the budget formulation process to take into account changes in health care delivery systems and Veteran demographics.

The total level of capital resources requested is reassessed each year in the annual budget process, where hard choices are made balancing capital needs identified in the SCIP 10-year plan and other VA priorities (such as the cost to provide medical care and Veteran benefits and services) in order to determine the appropriate level of funding for the fiscal year.

We are determined to provide our Veterans with access to high quality medical care and benefit services. Capital infrastructure is an essential part of our ability to achieve this vision

Conclusion

I appreciate the opportunity to testify on these important topics. With SCIP, VA has instituted a rigorous capital planning process that quantifies and prioritizes the need to repair, upgrade, dispose of, or replace VA's aging infrastructure and address the current and future needs of America's Veterans within the context of prudent capital investment decision-making.

VA must be prepared to meet projected health care demand and any future benefits delivery requirements. We are committed and will continue to work with Congress, Veteran Service Organizations and other stakeholders to refine and improve the SCIP process as needed. VA will continue to provide Veterans and their families with the benefits and world class medical services they have earned and deserve.

Prepared Statement of Lorelei St. James, Acting Director, Physical Infrastructure Issues, U.S. Government Accountability Office

VA REAL PROPERTY: Realignment Progressing, but Greater Transparency about Future Priorities Is Needed

GAO Highlights

Why GAO Did This Study

The Department of Veterans Affairs (VA) has undertaken various planning efforts to realign its real property portfolio, including the Capital Asset Realignment for Enhanced Services (CARES), creation of a 5-year capital plan, and its newest effort, the Strategic Capital Investment Planning process (SCIP). Through these efforts, VA has identified numerous real property priorities it believes should be completed if the agency's facilities are to meet veterans' needs for services now and in the future. In January 2011, GAO reported on the extent to which VA's capital planning efforts (1) have resulted in changes to its real property portfolio and (2) follow leading practices and provide information for informed decision-making. This statement summarizes the results of this report. To perform the work for the report, GAO reviewed leading capital planning practices and data on VA's real property portfolio and future priorities. GAO also interviewed VA officials and veterans service organizations and visited sites in 5 of VA's 21 veterans integrated service networks.

What GAO Recommends

In the report, GAO recommended that VA annually provide to Congress the full results of its SCIP process and any subsequent capital planning efforts, including details on estimated costs of future projects. VA concurred with this recommendation.

What GAO Found

GAO reported that, through its capital planning efforts, VA had taken steps to realign its real property portfolio from hospital based, inpatient care to outpatient care, but a substantial number of costly projects and other long-standing challenges also remain. Several of VA's most recent capital projects—such as community based outpatient clinics, rehabilitation centers for blind veterans, and a spinal cord injury center—were based on its CARES efforts and subsequent capital planning. VA officials and veterans service organizations GAO contacted agreed that these facilities have had a positive effect on veterans' access to services. However, VA had identified several high-cost priorities such as facility repairs and projects that have not yet been funded. For example, VA reported in its 5-year capital plan for fiscal years 2010–2015 that it had a backlog of $9.4 billion of facility repairs. The 5-year plan further identified an additional $4.4 billion in funding to complete 24 of the 69 ongoing major construction projects. Besides substantial funding priorities, GAO also found that VA, like other agencies, has faced underlying obstacles that have exacerbated its real property management challenges and can also impact its ability to fully realign its real property portfolio. GAO previously reported that such challenges include competing stakeholder interests, legal and budgetary limitations, and capital planning processes that did not always adequately address such issues as excess and underutilized property.

VA's capital planning efforts generally reflected leading practices, but lacked transparency about the cost of future priorities that could better inform decision-making. For example, VA's 2010–2015 capital plan linked its investments with its

strategic goals, assessed the agency's capital priorities, and evaluated various alternatives. Also, SCIP strengthened VA's capital planning efforts by extending the horizon of its 5-year plan to 10 years and providing VA with a longer range picture of the agency's future real property priorities. VA officials told GAO that SCIP builds on its existing capital planning processes, addresses leading practices, and further strengthens VA's efforts in some areas. GAO has not fully assessed SCIP and it remains to be seen what impact SCIP will have on the results of VA's capital planning efforts. While these changes were positive steps, GAO found that VA's planning efforts lacked transparency regarding the magnitude of costs of the agency's future real property priorities, which may limit the ability of VA and Congress to make informed funding decisions among competing priorities. For instance, for potential future projects, VA's 2010–2015 capital plan only listed project name and contained no information on what these projects were estimated to cost or the priority VA had assigned to them beyond what was then the current budget year. Transparency about future requirements would benefit congressional decision makers by putting individual project decisions in a long-term, strategic context, and placing VA's fiscal situation within the context of the overall fiscal condition of the U.S. government.

Chairman Miller, Ranking Member Filner, and Members of the Committee:

I am pleased to be here today as you examine construction planning issues related to the Department of Veterans Affairs (VA). VA is one of the largest Federal property-holding agencies, with more than 33,000 acres of land and over 5,500 buildings. VA uses this diverse inventory of real property to ensure that veterans receive medical care, benefits, social support, and lasting memorials. Over time, VA has recognized the need to modernize its facilities and realign its real property portfolio to provide accessible, high-quality, and cost-effective access to its services. Its Capital Asset Realignment for Enhanced Services (CARES) planning effort, which began over a decade ago, was designed to assess its building and land ownership in response to changing veterans' inpatient and outpatient demand for care. Since its 2004 CARES decision report, VA has undertaken additional planning efforts to realign its real property portfolio. For example, with its annual budget submission to Congress, VA began including 5-year capital plans that included information about projects it was seeking to start, as well as the estimated costs from first year through completion. More recently, VA developed a Strategic Capital Investment Planning (SCIP) process, which is intended to continue VA's efforts to prioritize its most urgent real property priorities. Through these capital planning efforts, VA has identified numerous real property priorities that it believes should be completed if the agency's facilities are to meet veterans' demand for services.

This statement is primarily based on our January 2011 report, which addressed the impact of CARES and the effectiveness of VA's capital planning process.[1] This statement addresses the following questions also covered in the report:

1. To what extent have VA's capital planning efforts resulted in changes to its real property portfolio and what priorities remain?
2. To what extent do VA's capital planning efforts follow leading Federal practices and provide the information needed for informed decision-making?

To perform this work, we reviewed leading capital planning practices and data on VA's real property portfolio and future priorities. We also interviewed VA officials and veterans service organizations, and visited sites in 5 of VA's 21 veterans integrated service networks. More detailed information on our scope and methodology can be found in appendix I of the report.

Our work was performed in accordance with generally accepted government auditing standards. This report did not assess the results of VA's capital planning proposals that are reflected in the President's fiscal year 2012 budget, which was released after our report was issued.

In summary, we found that through its capital planning efforts, VA had taken steps to realign its real property portfolio from hospital based, inpatient care to outpatient care, but a substantial number of costly projects and other long-standing challenges also remain. Several of VA's most recent capital projects—such as community based outpatient clinics, rehabilitation centers for blind veterans, and a spinal cord injury center—were based on its CARES efforts and subsequent capital planning. VA officials and veterans service organizations we contacted agreed that

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[1] GAO, *VA Real Property: Realignment Progressing, but Greater Transparency about Future Priorities Is Needed,* GAO–11–197 (Washington, D.C.: Jan. 31, 2011).

these facilities have had a positive effect on veterans' access to services. However, VA had identified several high-cost priorities such as facility repairs and projects that have not yet been funded. For example, VA reported in its 5-year capital plan for fiscal years 2010–2015 that it had a backlog of $9.4 billion of facility repairs. The 5-year plan further identified an additional $4.4 billion in funding to complete 24 of the 69 ongoing major construction projects. Besides substantial funding priorities, we also found that VA, like other agencies, has faced underlying obstacles that have exacerbated its real property management challenges and can also impact its ability to fully realign its real property portfolio. We have previously reported that such challenges include competing stakeholder interests, legal and budgetary limitations, and capital planning processes that did not always adequately address such issues as excess and underutilized property.

Furthermore, we found that VA's capital planning efforts generally reflected leading practices, but lacked transparency about the cost of future priorities that could better inform decision-making. For example, VA's 2010–2015 capital plan linked its investments with its strategic goals, assessed the agency's capital priorities, and evaluated various alternatives. Also, SCIP strengthened VA's capital planning efforts by extending the horizon of its 5-year plan to 10 years, and providing VA with a longer range picture of the agency's future real property priorities. VA officials told us that SCIP builds on its existing capital planning processes, addresses leading practices, and further strengthens VA's efforts in some areas. We have not fully assessed SCIP and it remains to be seen what impact SCIP will have on the results of VA's capital planning efforts. While these changes were positive steps, we found that VA's planning efforts lacked transparency regarding the magnitude of costs of the agency's future real property priorities, which may limit the ability of VA and Congress to make informed funding decisions among competing priorities. For instance, for potential future projects, VA's 2010–2015 capital plan only listed project name and contained no information on what these projects were estimated to cost or the priority VA had assigned to them beyond what was then the current budget year. Transparency about future requirements would benefit congressional decision makers by putting individual project decisions in a long-term, strategic context, and placing VA's fiscal situation within the context of the overall fiscal condition of the U.S. government. It is important to note that providing future cost estimates to Congress for urgent, major capital programs is not without precedent in the Federal Government. Other Federal agencies, such as the Department of Defense, have provided more transparent estimates to Congress regarding the magnitude of its future capital priorities beyond immediate budget priorities.

We concluded in our report that billions of dollars have already been appropriated to VA to realign and modernize its portfolio. Furthermore, VA had identified ongoing and future projects that could potentially require several additional billion dollars over the next few years to complete. Given the fiscal environment, VA and Congress would benefit from a more transparent view of potential projects and their estimated costs. Such a view would enable VA and Congress to better evaluate the full range of real property priorities over the next few years and, should fiscal constraints so dictate, identify which might take precedence over the others. In short, more transparency would allow for more informed decision-making among competing priorities, and the potential for improved service to veterans over the long term would likely be enhanced. To enhance transparency and allow for more informed decision-making related to VA's real property priorities, we recommended that the Secretary of Veterans Affairs provide the full results of VA's SCIP process and any subsequent capital planning efforts, including details on the estimated cost of all future projects, to Congress on a yearly basis. VA concurred with the recommendation. We have not yet assessed the extent to which VA has implemented our recommendation in relation to the President's 2012 budget.

Finally, I would also like to refer to a report we issued in December 2009, on VA construction.[2] This report may be relevant to today's discussion because it assessed VA's cost estimating approach for major projects. We found that while about half of 32 major ongoing construction projects we reviewed were within VA's budget, 18 projects experienced cost increases, and 11 had experienced schedule delays since they were first submitted to Congress. Five projects experienced a cost increase of over 100 percent. There were several reasons for construction project cost increases and schedule delays, including VA preparing initial cost estimates that were not thorough, significant changes to project scope after the initial estimate was submitted, and unforeseen events such as an increase in the cost of construction materials. VA had taken steps to improve initial construction project cost estimates, but

[2] GAO, *VA Construction: VA Is Working to Improve Project Cost Estimates, but Should Analyze Cost and Schedule Risks,* GAO–10–189 (Washington D.C.: Dec. 14, 2009).

we reported that it could better assess the risks to costs and schedules. We recommended that for all major projects, VA conduct a cost risk analysis, a schedule risk analysis when appropriate, and require the use of an integrated master schedule. VA concurred with our recommendations.

Chairman Miller, Ranking Member Filner, and Members of the Committee, this concludes my prepared remarks. I would be happy to answer any questions that you may have.

For further information regarding this statement, please contact Lorelei St. James at (202) 512–2834 or at stjamesl@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. David Sausville, Assistant Director; George Depaoli; and Erica Miles also made key contributions to this statement.

Prepared Statement of Raymond Kelley, Director, National Legislative Service, Veterans of Foreign Wars of the United States

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

On behalf of the 2.1 million men and women of the Veterans of Foreign Wars of the U.S. (VFW) and our Auxiliaries, I would like to thank you for the opportunity to testify today. Without adequate and accessible treatment facilities, delivery of care will be compromised. This hearing is the first step in ensuring that veterans not only receive the best care but also receive that care in a location and in a facility that best meets their needs.

VA's 2012–2021 Strategic Capital Investment Plan (SCIP) identified 4,808 capital projects, with a price tag that ranges between $53 and $65 billion. All of these projects will need to be completed to close condition, utilization, access, and space gaps.

Gap Analysis

Condition:

Currently, all VISNs have at least $100 million in "D" or "F" Facility Condition Assessments (FCA) gaps. Nine VISNs have more than $500 million in gaps, while four VISNs have more than $700 million in condition gaps. In VISN 3, there are $814 million in deficiencies. This occurred because of years of under funding for non-recurring maintenance (NRM). VFW is supportive of VA's 10-year capital plan, but we believe too much of the plan hinges on out-year funding. Current funding must be increased to achieve the SCIP plan. If VA requests and Congress appropriates the funding needed to complete the SCIP action plan, deficiencies across all VISNs will be reduced to approximately $200 million by FY 2021.

Utilization:

Utilization can be broken down into two categories: inpatient and outpatient. Inpatient utilization in 12 VISNs will decrease over the next 10 years, while nine will increase. Outpatient demand will increase in all 21 VISNs, with 14 VISNs projecting an increase in outpatient visits by over one million by 2018. In reviewing each of the VISN's plans to "right size" for patient demands, it appears to VFW that VA has well thought out plans to build new and/or reuse existing space where appropriate, lease when available, and demolish or mothball when necessary. In VA's 2012 Budget Submission, 131 vacant or underutilized assets will be repurposed for homeless housing, more than 128 will be either mothballed or demolished, and 17 will enter the extended use lease (EUL) program. Refitting and removal of these 276 buildings will save VA $18.5 million per year in maintenance costs alone. VFW supports VA's utilization gap reduction plan, but again we believe that too much of the financial burden will be placed on the out-years.

Accessibility:

Currently, seven VISNs are not meeting the 70 percent of enrollees residing within the VA drive-time goal. Under SCIP, all VISNs will meet the goal by 2021. This is being done mostly through increasing Community Based Outpatient Clinic (CBOC) leasing, which enables VA to place clinics in communities as veteran populations shift. VFW supports VA's accessibility gap reduction plan.

Space:

Many think that space inventory needs is currently reducing; however, space inventory is at a deficit at 12 of the 21 VISNs, and VA as a whole is at 125 percent capacity. Much of the deficit is in outpatient needs. VFW agrees with VA's plan of expansion for CBOCs to close 95 percent of the space gaps currently in place or projected by 2021.

Part of space management is deciding what to do with vacant or underutilized space. VA is aggressively repurposing many of its buildings, but there is a time when demolition may be necessary. Although VFW recognizes the need for the removal of buildings, we ask VA to provide more information on what the decision process looks like during consideration, as well as a history of the building, to include what the building was last used for, how long had it been vacant or underutilized, and whether EUL was considered as an option for the property. Overall, VFW believes VA's gap analysis for future usage and property management is acceptable.

Alternative investment planning

VFW is satisfied with VA's investment evaluation and consideration process for future needs. VA generally uses five criteria to determine the best and most financially sound capital investment plan. The criteria are: status quo, renovation, new construction, leasing, and contract out. VA weighs each of these options and provides an explanation of each option and rationale of their final decision on future capital planning.

The EUL program that was originally authorized in 1991 has formed public/private ventures that have generated annual revenue, cost avoidance and savings for VA. In FY 2010 alone, $61.5 million was off-set by EUL, and more than $266 million has been saved since 2006. EUL is due to expire at the end of this calendar year. Without re-authorization, VA's homelessness initiative will be jeopardized. Twenty-four current homelessness EULs and the planned repurposing of more than 100 underutilized buildings will be impacted. It is vital that EUL is re-authorized to enhance services to veterans, as well as reduce capital costs to VA.

Cost analysis and risk assessment

In VA's future needs consideration, cost analysis is always a consideration. VA expertly evaluates each critical gap and determines which construction option, whether it be leasing, renovating or building a new facility, makes the best financial sense but still provides the highest quality care with the easiest access for veterans. Cost alone should never be the lone factor for determining capital needs, and VFW is please that VA appears to use patient needs as a first step in deciding how to approach future building needs.

VFW is also concerned that delays in major construction projects will cost more if the projects are delayed. Ten major construction projects were designed and ready to begin construction in 2009. In FY 2012, only two of those projects have been identified to be funded. VFW believes that major construction projects should be funded to be completed within 5 years of initial funding.

Project prioritization

VFW views the SCIP prioritization process favorably. Unfortunately, funding does not reflect the same level of prioritization. Unless the out-years are funded much more aggressively than the current years, VA will not be able to meet demands, facilities will require more maintenance funding, and the priority list will continue to grow.

2012 construction budget request

VFW believes the 2012 capital budget request is extremely low. The current costs to fill the gaps that have been identified—which are planned to be corrected by 2021—are estimated to be between $52 and $65 billion. Investing $2.88 billion annually will not meet the needs of those gaps. VA is admittedly back-loading the capital plan by placing more than $16 billion in minor construction and NRM needs in the years 2017–2021. There were ten major construction projects that were schematic/design developed in FY 2009, yet only two of those projects were identified for funding in the FY 2012 budget request. VA cannot continue to push current needs to out-years. Buildings will only continue to deteriorate and the capital investment plan will only grow its deficit. VFW believes that VA's major construction account should be funded at $1.85 billion. This will allow them to complete all current, partially funded projects within 5 years, begin providing funding for 15 new projects, and complete all currently funded seismic corrections within 3 years. In FY 2010, NRM received a total of $2.1 billion. VA has requested only $871 million for NRM in FY 2012. This will fund only 190 of the more than 4,000 NRM projects re-

ported under SCIP. Minor construction is in better shape than major construction and NRM. Slight increases in the 2012 budget request will allow VA to easily eliminate minor construction gaps over the next 10 years. Leasing appears to be on track to close all related gaps within the desired time frame.

Viability of the 10-year plan

SCIP is thorough in its examination of current and future capital asset needs. It looks at multiple gaps that reduce the safety of employees and veterans and limit access and quality of care they are tasked to provide. VFW supports VA's SCIP 10-year plan, but recommends that funding be increased to match the infrastructure demand.

VA's capital budget plan comes from several line items: Lands and structures under medical facilities, and major and minor construction under VA construction accounts. The medical facilities account carries NRM and leasing. The FY 2010 actual for this account was $2.3 billion, with $2.15 billion used for NRM. The 2011 current estimate is already $200 million above the 2011 budget estimate, coming in at $1.4 billion. Even with this substantial increase in funding, 3,470 of the 4,808 identified capital projects within SCIP are NRM. The FY 2012 budget recommends an NRM budget of only $868.8 million. At this funding level, it will take 24 years to complete currently identified NRM projects.

If leasing line items are funded at the Administration's requested level, VA should be on track to maintain their current leases and fund the 61 new projects in FY 2012. VA has a plan to repurpose at least 131 buildings for the Secretary's homeless initiative, and EUL is needed to facilitate most of these programs. As mentioned before, EUL is due to expire at the end of 2011. It needs to be reauthorized.

Major construction projects accounts for the largest cost in capital planning. To complete the partially funded and to fully fund the 133 new projects in the FY 2012 SCIP plan, Congress will need to appropriate between $20 billion and $24.5 billion. VA plans to invest only $725 million—$545 million through appropriations request and $135.7 million in prior year unobligated funds—for major construction projects in FY 2012. At this pace, it will take about 30 years to fully fund VA's 10-year plan.

VA estimates that current and future minor construction projects will cost between $8 billion and $10 billion. Again, funding requests fell far short at only $550 million for FY 2012. At this pace, VA will take 14.5 years to reach its 10-year capital plan. Minor increases in current years will reduce the burden of these projects in out-years.

VFW believes the SCIP 10-year capital investment plan by itself is a solid plan. However, implementation of the plan is flawed. Asking for extremely low construction funding levels will cause the plan to fail. Closing access, utilization and deficiency gaps will only happen if Congress is committed to providing approximately $3.5 billion per year from FY 2017–2021 for minor construction and NRM alone.

In closing, VFW is impressed with the breadth and depth of VA's gap analysis and their process of determining corrective actions for those gaps. However, VFW would like to see more information on the building disposal process, as well as requests for funding that will set VA's capital plan on the right trajectory. VFW also requests that this Committee and Congress as a whole take a serious look at the long-term effects of not having a viable capital infrastructure for VA. Partnerships with medical universities will fade, training and recruitment of doctors will diminish, and vital research—which has been a tremendous recruitment tool for VA—will not be productive. VFW understands the Nation's financial trouble, reducing VA capital infrastructure spending will have second and third causes of effect that will cost taxpayers more in the long-term. There is no short-term fix to the VA infrastructure problem, so we must stop looking for one and begin funding VA construction at an appropriate level to set VA on a path of correcting gaps so current and future veterans will receive the care they earned and deserve.

Mr. Chairman, this concludes my testimony, I will be happy to answer any questions you or the Committee may have.

Prepared Statement of Kaiser Permanente

Kaiser Permanente would like to thank the Committee on Veterans Affairs of the United States House of Representatives for the invitation to answer specific questions at today's hearing.

The Kaiser Permanente Medical Care Program is the largest private integrated health care delivery system in the U.S., delivering health care to approximately 8.7 million members in nine States and the District of Columbia. Kaiser Permanente

is comprised of Kaiser Foundation Health Plan, Inc., the Nation's largest not-for-profit health plan, and its health plan subsidiaries outside California and Hawaii; the not-for-profit Kaiser Foundation Hospitals which operates 36 hospitals and over 400 other clinical facilities; and the Permanente Medical Groups, independent physician group practices that contract with Kaiser Foundation Health Plan to meet the health needs of Kaiser Permanente's members. The vast majority of medical, pharmacy, diagnostic, and laboratory services delivered to Kaiser Permanente members are performed within Kaiser Permanente.

Kaiser Permanente's capital scope includes expenditures in three major categories; new facility, information technology investments, and plant maintenance and renovations. Facility expenditures include investments in new hospitals, medical offices, and other ancillary space to meet growing membership needs and enable the internalization of care and services. These include both owned and leased space. Facility expenditures also include the cost of expansion of existing facilities, seismic upgrades, regulatory requirements, and maintenance projects. Ancillary space includes pharmacies and laboratories, as well as administrative space and business services.

The Professional Staff of the Committee contacted Kaiser Permanente to request input to this hearing in the form of specific questions regarding our own capital planning processes, as follows.

Questions and answers:

1. Does your organization use a cost analysis in planning construction or renovation projects for purchase or lease?

All capital projects require the submission of a business case for funding approval. There are predetermined thresholds, based on the dollar amount associated with the capital investment, which determine the specific requirements of each business case. The business case for major capital investments includes a full cost analysis of all operating expenditures and capital expenditures evaluated over a 10 year time frame. Individual cost analysis inputs (for example, costs expressed as dollars per square foot) are compared to internal metrics. Additionally, high level place holders are used for long range capital planning. These numbers are determined based on a high level internal cost model estimates. At the time of the actual funding request, business cases and options are developed and evaluated in more detail. Kaiser Permanente is in the process of developing benchmarks that are tied to external industry standards.

2. How is an analysis of alternatives conducted?

We assemble a comparative matrix that allows us to evaluate the short list of options for capital projects. This matrix includes the pertinent qualitative and quantitative drivers to the decisions (i.e. entitlements, parking, hard and soft costs, etc.)

It is the responsibility of the group who is submitting the business case to identify and evaluate the most relevant, realistic alternatives to proposed projects. Key considerations include——

- Can existing facilities accommodate forecasted service demand?
- Can existing facilities be renovated/modified to accommodate forecasted service demand more cost effectively?
- Is there an option to lease space for services in a way that is more financially beneficial to the organization?
- Is a lower cost venue available for purchase and renovation?
- Can the project be built using a smaller footprint? Reduced scope?
- Are there other providers in the market that can accommodate demand via contracting or partnership arrangement in an appropriate manner?
- Is there a higher and better use for the planned invested capital in other parts of the region?

In addition to describing these alternatives, regions are responsible for identifying and to the extent possible quantifying key risks associated with each alternative to the end of providing a full rationale for the recommended option.

3. On average, how many pages constitute a cost analysis of any given small and large project?

The length of a cost analysis really depends on the complexity of the cash flows and the transactions at hand. A typical business case includes the following in the cost analysis: comparative summary, net present value (NPV) analysis for each option under consideration, cash flow for each option considered, profit and loss (P& L) analysis for options considered and capital cost estimates for all options.

4. Who provides the analysis (internal to your organization or independent third party)?

Comprehensive cost analysis is generated, reviewed and approved internally.

5. Is the organization providing analysis contracted to provide the service? If so, is that expense valuable in overall cost savings related to your organizations decision?

This type of analysis is done using internal resources. While it's impossible to assign an accurate dollar amount to the value our organization receives through these thorough analyses, experience shows that a poorly planned investment can cost the organization millions of dollars over the life-cycle of a facility. For example, overbuilding a facility (building more square footage than is needed to meet market demands) increases both the initial investment and ongoing operational cost. It also "locks-up" capital resources that could be utilized to address other areas of need. Under-building a facility may force us to outsource services at a less efficient cost that could be achieved internally.

6. What is the value of comprehensive cost analysis in relation to your organization's construction or renovation projects?

Comprehensive cost analysis is an essential element of informed decision-making and project approvals at Kaiser Permanente. This type of analysis allows Kaiser Permanente to:

- better predict total project cost;
- appropriately plan and build a long-term, multi-year capital program;
- compare predictive cost models to our actual costs so that we may improve analysis of future projects;
- properly evaluate a range of options to make informed capital decisions going forward; and
- provide a benchmark against completed project cost and published industry cost data.

We hope that these answers are helpful to the Committee as it examines the Department of Veterans Affairs capital planning process. Kaiser Permanente would be happy to answer any additional questions the Committee may have.

Sacred Heart Health System
Pensacola, FL
April 4, 2011

Hon. Jeff Miller
House of Representatives
U.S. Congress

Hon. Bob Filner
House of Representatives
U.S. Congress

Dear Chairman Miller and Representative Filner:

I am Peter Heckathorn, Executive Vice President of Sacred Heart Health System in Pensacola, Florida. I lead strategic and operational planning for the health system and I have been in that role for 14 years. Prior to that I was involved in various health care organizations and was a consultant to large medical systems across the country.

Thank you for the opportunity to provide some information on how private health care organizations plan and budget for operations, technology, and facility investment. I apologize in advance for not being able to see you in person, but I suffered an acute medical condition that has temporarily blinded me in one eye and limits my ability to both write and travel.

Background

Sacred Heart Health System ("SHHS") is part of Ascension Health, the largest not-for-profit health care provider in the country, with physician clinics, hospitals, and nursing homes in 20 States. Ascension Health providers serve the full spectrum of populations, but with a special preference for the poor and vulnerable.

SHHS is an integrated health system providing physician care, inpatient community hospital services through 3 hospitals (with 543 beds operating at 80 plus percent occupancy), as well as highly specialized regional services such as heart sur-

gery, cancer care, and pediatric specialty services. SHHS provides primary and specialty physician care through clinics and medical offices for citizens throughout a 10 county region in western Florida and southern Alabama. SHHS also provides tertiary care for infants, children, and adults in a 20 county region including services for active duty military personnel and their dependents. Sacred Heart Hospital in Pensacola was named one of the best hospitals in the country in 2011 by HealthGrades, an independent organization that analyzes clinical quality outcomes for all hospitals. Additionally, Thomson Reuters named our Sacred Heart Hospital on the Emerald Coast in Destin one of the top 100 hospitals.

We are presently engaged in the annual development of an integrated strategic and financial plan that includes major capital projects. Over the last 10 years, SHHS has constructed two new hospitals and over a million square feet of ambulatory care space.

What I will share is a standard practice across the health care industry on how large, multi-region health systems engage in effective planning.

Strategic, Operational and Financial Planning Process

Health systems are driven to ensure careful and thoughtful financial stewardship and investment in the services for the communities we serve. Health care financial operating margins are very slim (averaging 1–2%), and the facility and technology driven nature of our industry demands tremendous amounts of capital investment. Careful planning and cash management are critical to survival. Therefore, it is incumbent on multi-regional systems to ensure that each of their local regional health systems annually create and update a 5-year strategic, operational, and financial plan to support that system's operating and capital expenditures budget.

A well-managed health system ("HS") will create an integrated strategic, operating and financial plan ("ISOF Plan") that incorporates the following elements in a detailed 5-year forecast document to be used by managers, executives, boards, and regional/national staff to track progress:

- Demographic and Market Analysis: Population, economic and health care statistics, trends, and forecasts are developed in a defined geographic market. Detailed population by age, gender, and race are analyzed for changes and trends, as well as employment, local business trends, and disease trends to assess their effects on the potential demand for services. Existing trends of utilization at the local regional system's facilities and other local facilities (including private and public) would be articulated and analyzed relative to the population and economic activity. All local trends and forecasts would be reviewed against national trends. Local, State, and Federal Government activities, financing, and regulations would all be scrutinized for implications on the demand for care and financing of services. All the data can be obtained from commercially available health information and planning companies who specialize in providing historical data, predictive demand and supply tools, and provide information regarding demographic and technology trends.
- Market Dynamics Review: Strategic and operating trends of other providers (including the VA medical facilities, the active-duty armed forces health care facilities) are analyzed for potential short-term and long-term impacts. In the private sector, there may be an avoidance of duplicating services or a need to provide a competitive service to maintain income viability as facilities compete on quality, customer service and clinical capability. The opportunities would be carefully balanced against the demographic analyses, preferred strategies, and financial investments and returns necessary to ensure organizational sustainability. This situation and opportunities analysis influences strategic planning goals.
- Strategy Plan: Most large health care organizations *have developed* strategies that are *derived* from their mission and *vision.* Those strategies would then be tailored through specific tactics to fit the specific market characteristics of the communities the regional health system serves. The operational implementation of each of these strategies should be addressed in the detail of the regional health system's ISOF Plan with concrete measureable performance goals. Performance against those goals should be tracked throughout the year by the local health system leadership, the regional/national system office, and the local boards of directors to ensure that the local ISOF Plan is *effectively* being pursued and implemented to further local regional and *collective* system-wide plans.
- Financial and Capital *Investment* Budgets: Annually, in concert with the strategic and operational planning process, a *5-year* financial and capital investment plan is created. These plans reflect the strategic and operating commitments of the local health system. The financial plan would only be approved for

1 year and although capital *investments* are listed, they are not approved for more than the current year without a far more detailed and rigorous process which is outlined below. It is the expectation that the *5-year* financial and capital plans will be reliable and consistent from year to year. Significant variation from year to year would be a major concern, unless major *events* (e.g., hurricane) occurred. Such variation would reduce the credibility of a local system seeking to add facilities and capacity or start a new location.

- Performance Evaluation: The ISOF Plan would be approved by the local regional health system's board and the national health system's board. Throughout the year, performance against the ISOF Plan's specific goals and financial plan would be *evaluated.* Most large private systems link *executive's* and management's compensation to the execution of the ISOF Plan goals.

Major New Technology or Building Projects

Major new technology and facility projects are analyzed separately from routine replacement of equipment. The financial plan described above includes routine capital replacements, including equipment and facility refreshes.

Major technology and capital projects (e.g. *over* $10 million in expenditures) would demand a multi-year conceptual planning lead time and detailed analysis before receipt of funding approval by the system-wide office. The process for approval and subsequent funding entails written justifications, analyses, and *reviews* in a thorough, disciplined, and documented process that *involves* multiple external and internal experts in planning, technology, operations, and finance. We shall call this the "capital project submission and *review* process."

Step* 1: *Initial Project Vetting

A prerequisite for a project to be qualified for the "submission" process is that the conceptual project has been identified and discussed in the specific local regional health system's *5-year* ISOF Plan as a critical goal to implement system strategy, and is in the local regional health system's capital *investment* budget as a priority that "outranks" other items it seeks. The creation of the ISOF Plan should *involve* a large number of stakeholders (e.g. staff, local health system board members [business and community leaders who live in the community)) in the preparation, critique, and refinement of the ISOF Plan document. Potential projects are carefully debated to ensure that the highest-priority, sustainable projects are conceived. Every year each local regional health system's ISOF Plan is also reviewed by an independent team at the system-wide office with the local regional executive that oversees the health system. Each local regional executive also annually presents their ISOF Plan and the proposed projects to other regional executives and system-wide leadership. This process provides for early constructive feedback on the potential project's strategic rationale, financial potential, and alternatives. This process also alleviates sudden crisis-driven projects.

It is expected that in each year's version of the ISOF Plan the local regional market statistics and strategies pertinent to a potential project would have been identified, articulated, and modified to identify key rationales and data promoting or proposing other alternatives to the project.

If the regional executive, after feedback from her or his peers, determines that a project has sufficient strategic and financial probability of success, then a "master facility plan" would be completed or updated. The master plan would be prepared by a multi-disciplinary team of independent outside consultants with specific expertise in health care planning, finance, operations, and facilities. There are many firms that provide these services. The master facility plan defines, and rigorously evaluates, current and future options including no action, delay, and modifications of current service capabilities against multiple demand and volume scenarios. This external assessment would have a significant influence on whether national system office staff will evaluate the potential project as sufficiently competitive to submit. The external consultants and system staff collectively identify trends that will affect in- and out-patient utilization and how those factors would manifest themselves in that specific community and in the organization's facilities. That detailed strategy, planning scenario, options, and facility-concepts testing process takes 6–8 months to complete. At every evaluation step in the process, the external consultants' findings are reviewed with the local regional health system.

Step* 2: *Project Review Upon Submission

If a project obtains a positive review in the "master facility plan," a conceptual project application package is created. This includes the master facility plan, preferred options and approaches to the project with a detailed integrated strategy, operating, and financial plan demonstrating various, but hopefully a high, cost-benefit

ratio. The project is then formally entered into the capital project submission and review process. Routinely, large national systems have a multi-disciplinary team of experts ("Capital Project Review Team") who review the conceptual project and its plan in entirety and provide a written analysis. Those experts generally are not involved in the local regional health system's operations and therefore can independently evaluate and rank all competing projects from the various local regional systems. The Capital Project Review Team ("CPRT") (made up of planning, finance, and operations staff integrated with design, construction, technology, and contracting staff) provide the ability to evaluate all potential aspects of a project. These experts may have selected the outside experts to perform the master facility plan. Their assessments coupled with input from the submitting regions' staff are vital to determining the project's viability, rationality, priority, and timing.

Acceptance by the CPRT is paramount for a project to proceed into the review portion of the process. The CPRT's rejection of a project would demand that the conceptual project and its plan be reworked. The CPRT team's acceptance is documented in a written summary of the conceptual project with specific cost/benefit metrics and forwarded to a system-wide committee ("System-Wide Committee") charged with allocating the limited 5-year forward-looking capital project budget. The capital budget is determined by the financial capacity of the whole national system's financial capacity and cannot exceed established limits in order to maintain credit ratings. Therefore, project ranking is critical. The System-Wide Committee would approve, pend, or deny a project. Approval by the Committee only means that the project can be imbedded in the multi-year ISFO Plan of the local regional system and has been "preliminary" approved subject to subsequent detailed analyses and agreed upon implementation timing.

Step* 3: *Preliminary Approval of Capital Projects

Once the preliminary approval is obtained, the local regional health system would commence to develop a functional design and operating program as well as an architectural schematic design. Upon completion of that work, which may be overseen by a system-wide facilities manager, the project is resubmitted to the CRPT for analysis. If the CRPT's analysis concludes that the preliminary-approved project will meet operating and financial objectives as originally submitted, it will recommend the project back the System-Wide Committee for a second approval review. The System-Wide Committee can approve, pend, or deny a project when the project is compared to other projects on the Committee's priority list and based on the system's current available capital. If a project exceeds a certain cost (e.g. $50 million) the project must go to the Board of Directors of the national system for approval. If the project was approved, then a "Not-To-Exceed" Budget" is created and the project is subjected to a "best practices test" to ensure that it will be the best possible facility before going to detailed design and bidding.

Step* 4: *Final Approval for Capital Projects

After the second national system approval, the project enters detailed design and budgeting. The expectation is that the results of this activity would result in a project ready for construction bidding. If during the detailed design and budgeting process, the project appears to have exceeded its approved scope or the detailed cost estimates determine that the project will exceed budget, the project is halted for a review with the system-wide CPRT and potentially facilities consults. If the capital costs cannot be modified to meet the budget and the performance objectives, then a project can be altered or canceled. Therefore, there is a careful focus at the preliminary stages of this process to ensure that the estimates employed are reasonable and consistent with industry standards. If the project *moves* forward to bidding and contracting, routine meetings, between regional management and the CPRT and facilities staff at the system-wide office, would occur (as frequently as monthly) to *review* time schedule and budget adherence. Any variation could result in the project being returned for a *review* by the senior executive level System-Wide Committee or the Board of Directors of the national system.

This process could, in theory, take only 2 years to get to drawings. However, based on the need to have orderly long term capital planning this process is more likely to have an elapsed time of 3 to 7 years. This necessitates extremely thoughtful and disciplined ISFO Plan processes and analytic capabilities.

Concepts to Potentially Consider:

In many communities, veterans have significant medical needs that cross the continuum of care and require specialized professionals. In our region there are hospitals with excess facility and clinical capacity, recognized high quality services, and experience with caring for active-duty personnel and veterans. Perhaps the VA should consider how to encourage public-private partnerships that would meet vet-

erans and active duty military needs using existing resources in communities in which the beneficiaries reside.

With implementation of new electronic health information exchanges between civilian and military health providers, access to medical history, testing results, and medical records will be even faster than before. Perhaps the VA might consider the alternatives of contracting with community physicians and hospitals to create quick access to care without the costs of building new facilities.

Thank you for letting me share some information and perspectives.

Respectfully,

Peter Heckathorn, CMPE
Executive Vice President

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Department of Veterans Affairs **News Release**

FOR IMMEDIATE RELEASE
February 10, 2011

VA & HUD Issue First-Ever Report on Homeless Veterans
Assessment Key to Preventing and Ending Homelessness

WASHINGTON—For the first time, the Department of Veterans Affairs (VA) and the Department of Housing and Urban Development today published the most authoritative analysis of the extent and nature of homelessness among Veterans. According to HUD and VA's assessment, nearly 76,000 Veterans were homeless on a given night in 2009 while roughly 136,000 Veterans spent at least one night in a shelter during that year.

This unprecedented assessment is based on an annual report HUD provides to Congress and explores in greater depth the demographics of Veterans who are homeless, how the number of Veterans compare to others who are homeless, and how Veterans access and use the Nation's homeless response system. HUD's report, Veteran Homelessness: A Supplement to the 2009 Annual Homeless Assessment Report to Congress, examines the data in the department's annual report to Congress in-depth.

"With our Federal, State and community partners working together, more Veterans are moving into safe housing," said Secretary of Veterans Affairs Eric K. Shinseki. "But we're not done yet. Providing assistance in mental health, substance abuse treatment, education and employment goes hand-in-hand with preventive steps and permanent supportive housing. We continue to work towards our goal of finding every Veteran safe housing and access to needed services."

Last June, President Obama announced the Nation's first comprehensive strategy to prevent and end homelessness, including a focus on homeless Veterans. The report, *Opening Doors: Federal Strategic Plan to Prevent and End Homelessness,* puts the country on a path to end Veterans and chronic homelessness by 2015; and to ending homelessness among children, family, and youth by 2020. *Read more about the Administration's strategic plan to prevent and end homelessness in America.*

Key Findings of Opening Doors: Federal Strategic Plan to Prevent and End Homelessness

- More than 3,000 cities and counties reported 75,609 homeless Veterans on a single night in January of 2009; 57 percent were staying in an emergency shelter or transitional housing program while the remaining 43 percent were unsheltered. Veterans represent approximately 12 percent of all homeless persons counted nationwide during the 2009 'point-in-time snapshot.'
- During a 12-month period in 2009, an estimated 136,000 Veterans—or about 1 in every 168 Veterans—spent at least one night in an emergency shelter or transitional housing program. The vast majority of sheltered homeless Veterans (96 percent) experienced homelessness alone while a much smaller share (four percent) was part of a family. Sheltered homeless Veterans are most often individual white men between the ages of 31 and 50 and living with a disability.
- Low-income Veterans are twice as likely to become homeless compared to all low-income adults. HUD and VA also examined the likelihood of becoming homeless among American Veterans with particular demographic characteristics. In 2009, twice as many poor Hispanic Veterans used a shelter at some point during the year compared with poor non-Hispanic Veterans. African American Veterans in poverty had similar rates of homelessness.
- Most Veterans who used emergency shelter stayed for only brief periods. One-third stayed in shelter for less than 1 week; 61 percent used a shelter for less than 1 month; and 84 percent stayed for less than 3 months. The report also concluded that Veterans remained in shelters longer than did non-Veterans. In 2009, the median length of stay for Veterans who were alone was 21 days in an emergency shelter and 117 days in transitional housing. By contrast, non-veteran individuals stayed in an emergency shelter for 17 days and 106 days in transitional housing.

- Nearly half of homeless Veterans were located in California, Texas, New York and Florida while only 28 percent of all Veterans were located in those same four States.
- The report studied the path homeless Veterans take into the shelter system and found most Veterans come from another homeless location and few entered the shelter system from their own housing or from housing provided by family or friends.
- Sheltered homeless Veterans are far more likely to be alone rather than part of a family household; 96 percent of Veterans are individuals compared to 63 percent in the overall homeless population.

For more information on VA's efforts to end homelessness among Veterans, visit VA's Web page at *www.va.gov/homelessness*.

[The VA/HUD's report, "Veteran Homelessness: A Supplement to the 2009 Annual Homeless Assessment Report to Congress," will be retained in the Committee files.]

U.S. Government Accountability Office
Washington, DC.
April 20, 2011

The Honorable Jeff Miller
Chairman
Committee on Veterans' Affairs
House of Representatives

Subject: *Response to Question for the Record; Committee on Veterans' Affairs, April 5, 2011, Hearing on "Deconstructing the U.S. Department of Veterans Affairs Construction Planning"*

Dear Mr. Chairman:

This letter responds to your question during the April 5, 2011, hearing entitled, *Deconstructing the U.S. Department of Veterans Affairs Construction Planning.*

We stated that we would answer by submitting a written response for the record. Our answer to the question is enclosed and is based on our previous work, updates to that work, and our knowledge of the areas addressed. Our previous work was conducted in accordance with GAO's quality assurance framework or generally accepted government auditing standards. We also asked the Department of Veterans affairs to verify the factual content of our response, and we incorporated their clarifications accordingly.

If you have any questions or would like to discuss our response, please contact me at (202) 512–2834 or stjamesl@gao.gov.

Sincerely yours,

Lorelei St. James
Acting Director, Physical Infrastructure Issues

Enclosure

Response to Hearing Question for the Record
Deconstructing the U.S. Department of Veterans Affairs Construction Planning
April 5, 2011
Committee on Veterans' Affairs, U.S. House of Representatives
Question for Lorelei St. James, Acting Director, Physical Infrastructure Issues, U.S. Government Accountability Office

Question from Chairman Jeff Miller

Do you know which of those suggestions the GAO made to VA were implemented [regarding recommendations in our report, *VA Construction: VA is Working to Improve Initial Project Cost Estimates but Should Analyze Cost and Risk Schedules, GAO–10–189 dated December 14, 2009*]?

As a part of its 2012 Congressional budget submission, VA provided an update on actions taken to implement GAO's recommendations regarding VA's cost esti-

mate process.[1] According to VA, these recommendations are partially implemented and are on target to be fully implemented in fiscal year 2011. We also asked VA to provide any updates to the implementation status. GAO publicly reports on agency progress in implementing recommendations—including those made to VA in GAO–10–189. GAO will continue to monitor and follow up on the implementation of the recommendations made to VA on this matter. More specifically:

Recommendation 1: To provide a realistic estimate of when a construction project may be completed as well as the risks to the project that could be mitigated, we recommend that the Secretary of Veterans Affairs direct the Office of Construction and Facilities Management (CFM) to require the use of an integrated master schedule for all major construction projects.[2] This schedule should integrate all phases of project design and construction.

- **Action Taken:** VA has reported progress, but has not yet fully implemented this recommendation. In VA's 2012 Congressional Budget Submission, VA reported that it was updating its internal guidance and requirements to incorporate integrated master schedules for all major construction projects. In the meantime, VA reported that at the outset of each new project, its project management teams were developing integrated master schedules for both the design and construction phases. According to VA, this recommendation will be fully implemented in fiscal year 2011.

Recommendation 2: To provide a realistic estimate of when a construction project may be completed as well as the risks to the project that could be mitigated, the Secretary of VA should direct CFM to conduct a schedule risk analysis, when appropriate, based on the project's cost, schedule, complexity, or other factors. Such a risk analysis should include a determination of the largest risks to the project, a plan for mitigating those risks, and an estimate of when the project will be finished if the risks are not mitigated.

- **Action Taken**: VA has reported progress, but has not yet fully implemented this recommendation. In its 2012 Congressional Budget Submission, VA reported that this recommendation was being incorporated into its internal guidance. In the meantime, it has updated its instructions to architectural/engineering contractors to reflect the need to consider schedule risk analysis during schedule development. According to VA, this recommendation also will be fully implemented in fiscal year 2011.

Recommendation 3: To improve estimates of the cost of a major construction project as well as the risks that may influence the cost and how these risks can be mitigated, the Secretary of VA should direct CFM to conduct a cost risk analysis of major construction projects.

- **Action Taken**: VA has reported progress, but has not yet fully implemented this recommendation. In its 2012 Congressional Budget Submission, VA reported that cost risk analysis considerations are also being addressed through updates of internal guidance. VA noted that the schedule risk considerations that architectural/engineering contractors were being instructed to consider, described above, would enable a better assessment of cost risk in the interim. According to VA, this recommendation also will be fully implemented in fiscal year 2011.

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[1] *The Department of Veterans Affairs: FY 2012 Budget Submission Summary Volume, Volume I of 4,* (Washington, D.C.: February 2011).

[2] An integrated master schedule should be horizontally and vertically linked. The schedule should be horizontally integrated, meaning that it should link the products and outcomes associated with already sequenced activities. The schedule should also be vertically integrated, meaning that traceability exists among varying levels of activities and supporting tasks and subtasks.

Committee on Veterans' Affairs
Washington, DC.
May 13, 2011

The Honorable Eric K. Shinseki
Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Mr. Secretary:

In reference to our full Committee hearing entitled, "Deconstructing the Department of Veterans Affairs Construction Planning," that took place on April 5, 2011, I would appreciate it if you could answer the following hearing questions by the close of business on June 10, 2011.

1. GAO's recent report on VA real property did not assess the extent to which the results of Strategic Capital Investment Planning (SCIP) are reflected in the President's fiscal year 2012 budget. How does SCIP respond to GAO's recommendation to provide the results of your capital planning efforts, including details on the estimated cost of all future projects, to Congress on a yearly basis? How will effectiveness measured be reported to Congress?
2. In the Department's fiscal year 2012 budget submission's discussion of the SCIP process, utilization gap is defined as "the difference between current workload and projected 2018 demand." When conducting future capital investment planning, did VA look at projected utilization rates beyond 2018, especially considering the Department's aging patient population? If not, why not? What is the justification behind the decision to project demand 7 years ahead to 2018?
3. Currently, activation and operational costs are not included in the SCIP analysis. However, the Committee was told that the Department was working on a plan to account for these crucial costs as part of SCIP. Please provide details as to how you intend to estimate these costs and make it transparent. Further, please provide an estimate for activation and operational costs for the new medical facility in Orlando, FL; New Orleans, LA; Denver, CO; and Las Vegas, NV as well as each major medical facility project submitted in the FY 2012 budget.
4. In January, the Government Accountability Office (GAO) issued a report on VA Real Property entitled "Realignment Progressing, but Greater Transparency about Future Priorities is Needed." You concurred with their recommendation to provide Congress with full SCIP results and subsequent capital planning efforts, including details on estimated future project costs annually. When can we expect to receive that information from the Department? Why was that information not provided previously?
5. In the past, GAO has reported that VA and the Department of Defense (DoD) lacked a joint nationwide market analysis to obtain information on what their combined future workloads in the areas of services, facilities, and patient needs would be and lacked performance measures that would be useful for evaluating how well they are achieving joint health care resource-sharing goals. Did SCIP address any of these deficiencies? If so, please provide a detailed account as to how VA conducted a nationwide market analysis to obtain information on what the VA and DoD combined future workloads were in the areas of services, facilities, and patient needs and what performance measures were used to evaluate if and how well you are achieving joint health care resource-sharing goals.
6. How will VA measure the effectiveness of SCIP, and how will VA inform Congress of its effectiveness?
7. GAO's recent report on VA real property did not assess the extent to which the results of SCIP are reflected in the President's fiscal year 2012 budget. How does SCIP respond to GAO's recommendation to provide the results of your capital planning efforts, including details on the estimated cost of all future projects, to Congress on a yearly basis? To what extent does SCIP define the gaps in meeting its capital investment needs?
8. The Department's total capital budget for FY 2012 is relatively low when compared with the SCIP estimated magnitude cost over the full 10 years. Please provide the Committee more detail on how the successive requests in following years will come to meet the estimated total SCIP costs.

9. Are all of the 10-year SCIP projections strictly based on a 10-year patient projection model? If not, please describe those variations. Please describe what tools the Department uses to arrive at its projected patient workloads at the 5-, 10-, and 20-year forecasts.
10. What methods, including Milliman utilization projection data, were used in VA analysis of options for future construction?
11. What impact, if any, do you believe the Patient Protection and Affordable Care Act will have on utilization rates for VA health care? Does VA expect that more low-income veterans will utilize private health care providers as a result of this law? If so, how will that impact the Department's capital investments?
12. In your written statement, you emphasized that in addition to ensuring access and safety for veterans and employees in VA facilities, "we must also ensure the efficient and effective use of taxpayer's dollars." Given that, please explain the discrepancy between the amount the Department identified as necessary to fulfilling the needs identified in the 10-year capital action plan (between $53 billion and $65 billion according to the Department's FY 2012 budget submission) and a FY 2012 request of $2.876 billion, less than 5 percent of that 10-year number.
13. What performance measures, if any, do you intend to employ to centrally monitor the implementation and impact of the SCIP plan and how will VA inform Congress of the effectiveness of SCIP?
14. What weight, if any, does the Department place on the overall fiscal condition of the Federal Government and the Nation's economy when conducting long-term strategic property planning?
15. To what extent does SCIP define VA's overarching, national strategy for its capital investments?
16. When did VA complete its most recent gap analysis, including facility condition assessments, of its capital investments and what were the results?
17. For access gap analysis under SCIP, please provide more specific information on how the criteria of drive-time and distance gaps are decided within a geographical area, and the likelihood of these criteria being modified during the 10-year SCIP implementation.
18. What is VA doing to address challenges in managing its real property, such as improving its project cost estimates?
19. How long does VA estimate it will take to complete the major and minor construction projects that are ongoing?
20. What is the percent weighting factor for reducing excess property that VA used to evaluate projects?
21. What are the factors and methodologies currently being considered for identifying activation costs and annual costs of VA facilities?
22. What will be the detailed recurring annual costs of the new and replacement VA Medical Center facilities, including maintenance and operation?
23. Of the 830 underutilized buildings identified by VA in the April 5 hearing, how many are 60 years or older? Of these buildings 60 years or older, how many are leased and how many are owned by VA?
24. What is the total number of buildings leased by VA? What is the total number of buildings owned by VA?
25. What plan is in place to speed up final disposition for the underutilized facilities?
26. Do the targeted energy efficiency and cost savings of 30 percent higher than current building standards create higher costs or slower contracting and construction than could otherwise be achieved? What are the targeted energy efficiency and cost savings at other large agencies?
27. The VA's Facility Condition Assessment (FCA) report compares the correction cost of buildings in poor or critical condition compared to the total replacement cost of the building. Is there a ratio of those two numbers that definitively decides whether VA will move toward one action or the other, and if so what is that ratio? If there is not a definitive ratio in the FCA report, what are other factors that dictate whether to correct versus replace a facility?
28. In a report recently submitted to the Committee by the Secretary outlining construction and design contracts not awarded by the end of the last fiscal year, the replacement medical center facility in Denver, Colorado, was referenced. Funds have been appropriated for this project since Fiscal Year 2004, and yet the Phase I demolition was not awarded until April 2009. The report tells the Committee that the "project went from a replacement medical center to a super clinic, then back to a replacement medical center on a *smaller* (emphasis added) scale than the original project." Can you explain to this com-

mittee how the planning started with one size, got significantly bigger, then significantly smaller?

29. Another contract that was not awarded in the expected time pertains to the replacement medical center in New Orleans. The city of New Orleans and the state of Louisiana were expected to transfer the remaining property to VA by early March 2011. Did this transfer happen?
    a. Does the transfer mentioned in the report relate to privately-owned property that officials have taken over using eminent domain? How many residents have been displaced because of this project?
30. Please provide a status update on all 10 of the projects listed in that report.
31. What is the review process when revising a construction project, such as a change in the square footage of the facility?
32. How and by whom are cost analyses conducted and reviewed by the Department when examining facility construction options? What are the contents of these analyses?
33. Has VA ever considered using an independent review process to make an unbiased decision given all possible alternatives related to VA facilities? If so, why has this process not been adopted yet?
34. What are VA's plans to reduce the $9.4 billion backlog in repairs?
35. The Capital Asset Realignment for Enhanced Services (CARES) process identified a gap in inpatient care in Far South TX. However, the CARES Commission did not recommend constructing a small VA hospital in this region because: a single location would not accommodate the dispersed veteran population; the low volume need could not support a full range of specialty care; and veterans would still be required to travel to the San Antonio Veterans Affairs Medical Center for specialty care. CARES did recommend constructing a large specialized outpatient health care center (HCC) in collaboration with the University of Texas Regional Academic Health Center and establishing contracts with the large well-regarded multi-specialty private hospitals for inpatient care in the region. In January of this year, VA opened a new Health Care Center (HCC) at Harlingen, TX. However, some stakeholders remain concerned that an inpatient VA medical center in Far South Texas is essential. Did the Strategic Capital Investment Planning (SCIP) process evaluate the need for an inpatient VA hospital in Far South Texas? If so, please provide details as to the outcome of the SCIP evaluation. Additionally, please provide VA's views on the sufficiency of the existing infrastructure and services in Far South Texas to meet the current and future demand for veterans' health care and any recommendations for the need for enhanced services.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Diane Kirkland at diane.kirkland@mail.house.gov. If you have any questions, please call 202–225–3527.

Sincerely,

JEFF MILLER
Chairman

The Honorable Jeff Miller, Chairman
House Committee on Veterans Affairs
"Deconstructing the Department of Veterans Affairs Construction Planning," April 5, 2011 Hearing

Question 1: GAO's recent report on VA real property did not assess the extent to which the results of Strategic Capital Investment Planning (SCIP) are reflected in the President's fiscal year 2012 budget. How does SCIP respond to GAO's recommendation to provide the results of your capital planning efforts, including details on the estimated cost of all future projects, to Congress on a yearly basis? How will effectiveness measured be reported to Congress?

Response: The SCIP plan was released after the final GAO report was issued. The SCIP plan lists the projects and estimated costs to be addressed in FY 2012. It also details the projects (including location, description, and estimated cost) and other investment levels needed to meet gaps for fiscal years 2013–2021.

The SCIP process determines the investments needed to address gaps in space, access, safety, facility condition, efficiencies, and utilization. SCIP's main objective is to identify VA infrastructure gaps and propose a systematic and integrated plan to address those needs. Therefore, the current metrics used to measure effectiveness are primarily process-focused. For example, a key measure was the prioritized list of projects and 10-year SCIP plan delivered on-time along with the Department's budget. Other measures that are tracked include the number of VA staff who are trained on important SCIP elements and requirements, and the percentage of projects in budget execution that were reviewed during the SCIP process. In the future, once projects are funded, constructed and in use, VA will be able to measure their impact on the various SCIP-identified gaps. Measured results will be included in future VA budget and SCIP submissions.

Question 2: In the Department's fiscal year 2012 budget submission's discussion of the SCIP process, utilization gap is defined as "the difference between current workload and projected 2018 demand." When conducting future capital investment planning, did VA look at projected utilization rates beyond 2018, especially considering the Department's aging patient population? If not, why not? What is the justification behind the decision to project demand 7 years ahead to 2018?

Response: Yes, VA looks at projected utilization rates across a 20-year planning horizon to identify and plan appropriately for the degrees of growth or decline across the planning horizon. SCIP uses a 10-year planning horizon (the current workload used in this case is base year 2008 projections) as a realistic time frame for estimating future capital requirements, but within the context of 20-year projections. Analyzing long-term demand trends help ensure, for example, projects are not over built where a near-term peak in demand is followed by a steady decline. The 20-year projections are generated by VA's Enrollee Health Care Projection Model, which is supported by Milliman, Inc., the largest health care actuarial consultancy in the U.S.

Question 3: Currently, activation and operational costs are not included in the SCIP analysis. However, the Committee was told that the Department was working on a plan to account for these crucial costs as part of SCIP. Please provide details as to how you intend to estimate these costs and make it transparent. Further, please provide an estimate for activation and operational costs for the new medical facility in Orlando, FL; New Orleans, LA; Denver, CO; and Las Vegas, NV as well as each major medical facility project submitted in the FY 2012 budget.

Response: VA is currently working on a methodology to include estimated activation costs for future SCIP projects. These costs will be included in FY 2013 and future plans.

Question 4: In January, the Government Accountability Office (GAO) issued a report on VA Real Property entitled "Realignment Progressing, but Greater Transparency about Future Priorities is Needed." You concurred with their recommendation to provide Congress with full SCIP results and subsequent capital planning efforts, including details on estimated future project costs annually. When can we expect to receive that information from the Department? Why was that information not provided previously?

Response: The SCIP plan lists the projects and estimated costs to be addressed in FY 2012. It also details the projects (including location, description, and estimated cost) and other investment levels needed to meet gaps for fiscal years 2013–2021. Prior VA 5-Year Capital Plans did include costs for budget year projects and estimated costs for other high priority major construction and leasing projects. The future costs in the current SCIP plan were provided along with the assumption that they are a "snap shot" of magnitude costs that will be refined as projects move through the budget process including preparation of OMB 300 business cases, prospectus details provided in budget submission and at completion of project design.

Question 5: In the past, GAO has reported that VA and the Department of Defense (DoD) lacked a joint nationwide market analysis to obtain information on what their combined future workloads in the areas of services, facilities, and patient needs would be and lacked performance measures that would be useful for evaluating how well they are achieving joint health care resource-sharing goals. Did SCIP address any of these deficiencies? If so, please provide a detailed account as to how

VA conducted a nationwide market analysis to obtain information on what the VA and DoD combined future workloads were in the areas of services, facilities, and patient needs and what performance measures were used to evaluate if and how well you are achieving joint health care resource-sharing goals.

Response: The SCIP process did not include information on combined VA/DoD future workloads in the areas of services, facilities, and patient needs. However, both VA and DoD capital investment methodologies include criteria that credits these types of projects during the prioritization and ranking process. In addition, the Joint Executive Council (JEC) through its Construction Planning Committee (CPC) is currently exploring ways to develop more robust VA/DoD joint strategic capital planning. This includes realigning existing planning processes and funding mechanisms to allow for additional joint ventures that would enhance services to Veterans.

All construction projects submitted for the current VA Strategic Capital Investment Planning (SCIP) process were reviewed by staff in the DoD Collaboration Office to determine opportunities for joint construction. DoD staff also reviewed the current SCIP submissions and participated in the SCIP review process. This transparency of VA construction proposals and evaluation process provided multiple chances for DoD and VA to identify future joint construction opportunities throughout the SCIP. VA is invited to participate in DoD's Capital Investment Decision Model (CIDM) process when DoD will prioritize proposed construction projects.

There currently are feasibility studies being conducted in Fort Leavenworth, KS; Wichita, KS; and Bremerton, WA to determine the need/justification for joint construction projects in those geographic areas, again, based on populations and workload. The Fort Leavenworth study is a joint effort between the Army and VA; Wichita is between Air Force and VA; and Bremerton is between Navy and VA. All studies are nearing completion. Pending this nationwide analysis, we have begun to analyze joint markets where construction needs have been identified, to determine the combined services, facilities, and patient needs. A combined multi-service market analysis has just been completed for the Oahu market. This study examined the populations and health care requirements for all military markets including Army, Navy, and Air Force, plus VA.

Question 6: How will VA measure the effectiveness of SCIP, and how will VA inform Congress of its effectiveness?

Response: The SCIP process determines the investments needed to address gaps in space, access, safety, facility condition, efficiencies, and utilization. SCIP's main objective is to identify VA infrastructure gaps and propose a systematic and integrated plan to address those needs. Therefore, the current metrics used to measure effectiveness are primarily process-focused. For example, a key measure was the prioritized list of projects and 10-year SCIP plan delivered on-time along with the Department's budget. Other measures that are tracked include the number of VA staff who are trained on important SCIP elements and requirements, and the percentage of projects in budget execution that were reviewed during the SCIP process. In the future, once projects are funded, constructed and in use, VA will be able to measure their impact on the various SCIP-identified gaps. Measured results will be included in future VA budget and SCIP submissions.

Question 7: GAO's recent report on VA real property did not assess the extent to which the results of SCIP are reflected in the President's fiscal year 2012 budget. How does SCIP respond to GAO's recommendation to provide the results of your capital planning efforts, including details on the estimated cost of all future projects, to Congress on a yearly basis? To what extent does SCIP define the gaps in meeting its capital investment needs?

Response: The SCIP plan lists the projects to be addressed in FY 2012. It also details the projects (including location, description, and estimated cost) and other investment levels needed to meet gaps for fiscal years 2013–2021. The future costs in the current SCIP plan were provided along with the assumption that they are a "snap shot" of magnitude costs that will be refined as projects move through the budget process including preparation of OMB 300 business cases, prospectus details provided in budget submission and at completion of project design. SCIP incorporates service gaps to identify the Department's capital investment needs. Service gaps are identified at the Departmental level for the Administrations.

Question 8: The Department's total capital budget for FY 2012 is relatively low when compared with the SCIP estimated magnitude cost over the full 10 years. Please provide the Committee more detail on how the successive requests in following years will come to meet the estimated total SCIP costs.

Response: An important goal of SCIP was to identify the full extent of the problem. The SCIP 10-Year Action Plan identified $53–$65 billion in magnitude cost estimates over the course of the 10-year planning horizon needed to close performance gaps. A second goal of SCIP was to start a national conversation about the best way to close our gaps and ensure we are providing Veterans, their families, and their survivors with the best services and care. VA's 2012 budget submission reflects the hard choices that were made in order to balance the construction needs identified in the SCIP 10-year plan and other VA priorities (such as the cost to provide medical care and Veteran benefits and services).

The SCIP plan provides a rational, data-driven strategic framework to ensure capital investments are focused on the most critical infrastructure needs first and these investments are then funded in priority order. All projects are prioritized based on identified needs and the ability to close known performance gaps. The SCIP plan will be updated every year allowing for changes in health care delivery technologies, cost saving solutions and changing Veteran demographics to be incorporated into the process. VA will work with Congress and the VSO's to implement the SCIP plan. We look forward to working with Congress to come up with effective solutions to closing these gaps.

Question 9: Are all of the 10-year SCIP projections strictly based on a 10-year patient projection model? If not, please describe those variations. Please describe what tools the Department uses to arrive at its projected patient workloads at the 5-, 10-, and 20-year forecasts.

Response: No, the utilization (patient) projection model produces annual utilization projections out over a 20-year planning horizon. The 20-year projections are generated by VA's Enrollee Health Care Projection Model (EHCPM), which is supported by Milliman, Inc., the largest health care actuarial consultancy in the U.S. The EHCPM is an assumption-based demand projection model. The multitude of assumptions used in this model make it possible to project future utilization and expenditures by making explicit assumptions (through research and analysis) about how specific utilization and expenditure patterns may differ from current patterns under various scenarios. The model projects enrollment, utilization, and expenditures for the enrolled Veteran population for over 60 categories of health care services for each of the 20 projection years, allowing multiple planning horizon options. First, the model determines how many Veterans will be enrolled in VA in each projection year and their age, priority, and geographic location. Next, the model projects the total health care services needed by those enrollees and then estimates the portion of that care that those enrollees will demand from VA.

Question 10: What methods, including Milliman utilization projection data, were used in VA analysis of options for future construction?

Response: SCIP is a data driven process based on service and infrastructure gaps. Future construction projects are defined as part of SCIP based on the gaps identified for closure. Each gap area has a process or method used to identify the service gap and quantity of gap that needs to be addressed. For workload/utilization, the Milliman model projects workload need in the future. This future need is then compared with the current actual workload facility by facility. In cases where future demand is projected to be higher than current demand, a gap is identified that must be filled through SCIP. The workload/utilization demand projections from Milliman are also used to generate the space gap used in SCIP. Using VA's space criteria, the Milliman projections are converted into actual Gross Square Feet required, then compared to the current space available or space that will become available in the future to meet this demand. The gap is determined by comparing the future need for space with the available space, resulting in either more space being required or excess space for disposal. The remaining gaps, such as security, energy, access, and condition, use current data to compare to a standard or target to define the service gap to be addressed in SCIP. As shown here, SCIP uses detailed methods and processes to define all gaps that potentially could require future construction.

Question 11: What impact, if any, do you believe the Patient Protection and Affordable Care Act will have on utilization rates for VA health care? Does VA expect that more low-income veterans will utilize private health care providers as a result of this law? If so, how will that impact the Department's capital investments?

Response: VHA created a task force in 2009 that continues to monitor proposed health care reform legislation for potential impacts on VHA health care. VHA does not yet have any projections on impact to the system as the regulatory process is still in its infancy.

Question 12: In your written statement, you emphasized that in addition to ensuring access and safety for veterans and employees in VA facilities, "we must also ensure the efficient and effective use of taxpayer's dollars." Given that, please explain the discrepancy between the amount the Department identified as necessary to fulfilling the needs identified in the 10-year capital action plan (between $53 billion and $65 billion according to the Department's FY 2012 budget submission) and a FY 2012 request of $2.876 billion, less than 5 percent of that 10-year number.

Response: An important goal of SCIP was to identify the full extent of the problem. The SCIP 10-Year Action Plan identified $53–$65 billion in magnitude cost estimates over the course of the 10-year planning horizon needed to close performance gaps. A second goal of SCIP was to start a national conversation about the best way to close our gaps and ensure we are providing Veterans, their families, and their survivors with the best services and care. VA's 2012 budget submission reflects the hard choices that were made in order to balance the construction needs identified in the SCIP 10-year plan and other VA priorities (such as the cost to provide medical care and Veteran benefits and services). The SCIP plan provides a rational, data-driven strategic framework to ensure capital investments are focused on the most critical infrastructure needs first and these investments are then funded in priority order. All projects are prioritized based on identified needs and the ability to close known performance gaps. The SCIP plan will be updated every year allowing for changes in health care delivery technologies, cost saving solutions and changing Veteran demographics to be incorporated into the process. VA will work with and keep Congress informed of progress on implement of the SCIP. We look forward to working with Congress to come up with effective solutions to closing these gaps.

Question 13: What performance measures, if any, do you intend to employ to centrally monitor the implementation and impact of the SCIP plan and how will VA inform Congress of the effectiveness of SCIP?

Response: The SCIP process determines the investments needed to address gaps in space, access, safety, facility condition, efficiencies, and utilization. SCIP's main objective is to identify VA infrastructure gaps and propose a systematic and integrated plan to address those needs. Therefore, the current metrics used to measure effectiveness are primarily process-focused. For example, a key measure was the prioritized list of projects and 10-year SCIP plan delivered on-time along with the Department's budget. Other measures that are tracked include the number of VA staff who are trained on important SCIP elements and requirements, and the percentage of projects in budget execution that were reviewed during the SCIP process. In the future, once projects are funded, constructed, and in use, VA will be able to measure their impact on the various SCIP-identified gaps. Measured results will be included in future VA budget and SCIP submissions.

Question 14: What weight, if any, does the Department place on the overall fiscal condition of the Federal Government and the Nation's economy when conducting long-term strategic property planning?

Response: VA works closely with the Office and Management and Budget in order to ensure the fiscal condition of the Nation is fully integrated into our long term planning. OMB provides the current and economic indexes rates (such as discount, inflation rate and economic indicators) used in developing many of our capital planning tools and documents.

Question 15: To what extent does SCIP define VA's overarching, national strategy for its capital investments?

Response: The Strategic Capital Investment Planning's (SCIP) approach to capital programs reflects VA's priorities and good stewardship of resources to maximize benefits and services to Veterans. SCIP demonstrates effectiveness and accountability by developing a comprehensive review of requirements and prioritizing construction needs across all VA organizations. VA's capital program is driven by the strategic direction embodied in SCIP—to close performance gaps and provide sufficient capital to ensure Veterans receive the best service in facilities that are:

- Safe and secure
- Located closer to where Veterans live
- Modern and state-of-the-art
- Capable of supporting the demand for services and benefits
- Able to serve homeless Veterans through use of vacant facilities

Question 16: When did VA complete its most recent gap analysis, including facility condition assessments, of its capital investments and what were the results?

Response: VA completes gap analysis for SCIP on an annual basis. The gap analysis for FY 2012 SCIP was completed in January 2010. Each gap area represented in SCIP, such as space or condition, has an analysis performed in support of the annual process. For example, condition assessments are completed throughout the year and summarized in the annual gap analysis. Other gap areas, such as space and energy, are tracked throughout the year and the final end of year numbers are used to perform the gap analysis. The results of the gap analysis performed for SCIP are represented in VA's FY 2012 budget for each gap area, by administration.

Question 17: For access gap analysis under SCIP, please provide more specific information on how the criteria of drive-time and distance gaps are decided within a geographical area, and the likelihood of these criteria being modified during the 10-year SCIP implementation.

Response: VA's current drive-time access guidelines grew out of VA's recognition that improving access to Veteran care was necessary to improve the quality and value of services. As early as the mid-1990s, a structured process of objective data capture, systematic measurement, and monitoring of outcomes and benchmarks was developed as a vehicle for VHA leaders to manage access performance and promote accountability. The current drive-time guidelines, developed during the Capital Asset Realignment for Enhanced Services (CARES) study, have been used by VHA to assess and manage health care access, and when making Capital asset decisions. A work group is currently conducting a comprehensive review of existing drive-time guidelines and will make recommendations for improvements as necessary. The recommendations and findings of the work group will enhance VHA's capability to plan for access expansion as well as make accurate policy decisions regarding Veterans' access to health care and capital budgeting.

Question 18: What is VA doing to address challenges in managing its real property, such as improving its project cost estimates?

Response: VA does indeed face many challenges in managing its capital portfolio of over 5,500 owned buildings (143 million square feet), with an average age greater than 60 years. (VA's portfolio includes 1,594 historic buildings.) SCIP represents the best mix of projects including the action plans that contain magnitude cost estimates based on a "snapshot" in time. Project costs are refined and improved as the project moves along in the budget process—beginning with the magnitude cost found in the action plan, refined at the business case submission, and later through the detailed OMB 300 business case. The estimated costs are improved and provided in the project prospectus in the budget submission and may be updated again at completion of project design. VA is also working to develop a methodology for including activation (project estimated start-up cost) in future SCIP plans beginning with the 2013 SCIP submission.

Question 19: How long does VA estimate it will take to complete major and minor construction projects that are ongoing?

Response: The level of major construction funding provided will have a critical and direct impact on the time it takes to complete all ongoing projects. There are currently 23 partially funded major construction projects that total approximately $6 billion in remaining need. In order to maximize resources, VA requests funds for phased major projects based on the project's schedule and its ability to obligate in the request year. VA anticipates a large majority of partially funded minor construction projects will be obligated by the end of FY 2012.

Question 20: What is the percent weighting factor for reducing excess property that VA used to evaluate projects?

Response*:* The two sub-criteria focused specifically on reducing excess property are Space—Repurposing and Space—Demolition, each of which are valued at a maximum of 1.2 percent of the project score. However, capital projects were evaluated on 18 distinct sub-criteria for the FY 2012 SCIP process, several of which can apply to a project that reduces excess property. The Repurposing and Demolition sub-criteria are part of the Right-Sizing Inventory major criterion that is ranked 5th out of the 6 major criteria. Another component of the project score is the rating factor applied to each sub-criterion. The rating factor applied to both the Repurposing and Demolition sub-criteria is the percentage of the gap filled. Not all projects will earn a rating of 1 (the highest possible rating) for these sub-criteria.

A project that reduces excess space can earn points for various other sub-criteria. For example, a project that reduces excess property could also receive points for any combination of the following sub-criteria: Safety/Compliance (10.9 percent); Seismic (11.4 percent); Supporting Initiatives (3.3 percent); Energy Standards (3.9 percent); Best Value Solutions (3.6 percent); and Maximize Efficiencies (1.2 percent). Percentage values represent the maximum point value.

Major Construction Projects Funded FY 2006–2011

Location		Description	Total Estimated Cost	Funding Year	Estimated Completion Date	Status
VHA Major Construction Projects:						
Gainesville	FL	Correct Patient Privacy Deficiencies	114,200,000	2004	15–Jun–11	CO
Las Vegas	NV	New Medical Facility (Overview)	593,500,000	2004	30–Apr–13	CO
Long Beach	CA	Seismic Corrections/Clinical,B–7 & 126	129,545,000	2004	28–Feb–14	CO
Orlando	FL	New Medical Facility (Overview)	665,400,000	2004	30–Oct–12	CO
Palo Alto	CA	Seismic Corrections, Bldg. 2 (Overview)	54,000,000	2004	30–Nov–11	CO
Pittsburgh	PA	Medical Center Consolidation (Overview)	295,594,471	2004	28–Feb–14	CO
Atlanta	GA	Modernize Patient Wards (Overview)	24,534,000	2005	1–Feb–12	CO
Bay Pines	FL	Outpatient Clinic (Lee County)	89,800,000	2005	30–Sep–11	CO
San Juan	PR	Seismic Corrections Bldg. 1 (Overview)	277,000,000	2005	30–Sep–14	CO
Syracuse	NY	Addition For SCI Center (Overview)	86,969,000	2005	13–Jul–12	CO
Biloxi	MS	Restoration Of Hospital/Consolidation of Gulfport (Overview)	304,000,000	2006	30–Nov–12	CO
Denver	CO	New Medical Center Facility (Overview)	800,000,000	2004/05	28–Feb–14	CO
Fayetteville	AR	Clinical Addition	90,600,000	2006/08	20–Sep–12	CO
New Orleans	LA	New Medical Facility (OV)	995,000,000	2006	30–Dec–14	CD
Columbia	MO	Operating Suite Replacement	25,830,000	2007	28–Jan–13	CO
Milwaukee	WI	Spinal Cord Injury Center	29,500,000	2007	31–May–11	PC
St. Louis (JBD)	MO	Med Facility Improv & Cem Expansion (Overview)	346,300,000	2007	TBD	CO
Palo Alto	CA	Centers for Ambulatory Care/Polytrauma-Blind Rehabilitation (Overview)	716,600,000	2008	TBD	CO
San Antonio	TX	Polytrauma Center, & Renovation of Exist Bldg. 1 (Overview)	66,000,000	2008	1–Apr–13	CO
Tampa	FL	Polytrauma Expansion/Bed Tower (Overview)	231,500,000	2008	TBD	CO
American Lake	WA	Seismic Corrections of Bldg. 81	52,600,000	2009	TBD	DD
Bay Pines	FL	Inpatient/Outpatient Improvements (Overview)	158,200,000	2009	TBD	CO
Bronx	NY	Spinal Cord Injury Center (SCI) (Overview)	225,900,000	2009	TBD	S/DD
Dallas	TX	Clinical Expansion for Mental Health	156,400,000	2009	TBD	DD
Louisville	KY	New Medical Facility	TBD	2009	TBD	MP
Omaha	NE	Omaha—Replacement Facility	560,000,000	2009	TBD	S/DD
Seattle	WA	B101 Mental Health (Overview)	211,700,000	2009	TBD	DD

Major Construction Projects Funded FY 2006–2011—Continued

Location		Description	Total Estimated Cost	Funding Year	Estimated Completion Date	Status
Walla Walla	WA	Multi Specialty Care (Overview)	71,400,000	2009	TBD	CO
West Los Angeles	CA	Seismic Corrections—Various Bldgs. (Overview)	326,900,000	2009	TBD	DD
Brockton	MA	Long-Term Care Spinal Cord Injury (SCI) (Overview)	188,000,000	2010	TBD	DD
Canandaigua	NY	New Construction and Renovation	370,100,000	2010	TBD	S/DD
Long Beach	CA	Seismic Corrections—Mental Health & Community Living Center	258,400,000	2010	TBD	DD
Palo Alto	CA	Livermore Realignment (OV)	354,300,000	2010	TBD	SD
Perry Point	MD	Replacement CLC	90,100,000	2010	TBD	AE
Saint Louis	MO	New Bed Tower, Research Building, Parking Garage (Overview)	433,400,000	2010	TBD	AE
Temple	TX	Information Technology (IT) Building	10,552,000	2009	27–Jan–12	CO
San Diego	CA	SCI, Seismic Corrections—(Overview)	195,000,000	2010	TBD	DD
Sacramento	CA	Alameda Outpatient Clinic	208,600,000	2011	TBD	AE
NCA Major Construction Projects:						
San Diego	CA	Miramar Natl Cem—Master Plan and Phase I Development of Miramar Annex	26,450,000	2006	20–Jan–12	CO
Bakersfield	CA	New National Cemetery—Phase 1B	16,232,492	2008	20–Aug–11	CO
Columbia/ Greenville	SC	Ft. Jackson Natl Cem—New National Cemetery—Phase 1B Development	16,196,072	2008	10–Sep–11	CO
Ft. Sam Houston	TX	Phase B—Infrastructure Repairs (SHPO)	11,000,000	2008	1–May–13	CD
Jacksonville	FL	New Cemetery—Phase 1 B Development	16,166,438	2008	11–Jul–11	CO
Philadelphia	PA	Washington Crossing Natl Cem—New Cemetery—Phase 1B Development	23,636,000	2008	14–Feb–12	CO
Sarasota	FL	New National Cemetery—Phase IB Development	23,187,232	2008	12–Jul–12	CO
Bayamon	PR	Puerto Rico Natl Cem—Gravesite Exp & Cemetery Improv on Remaining Land	33,900,000	2009	16–Oct–12	CO
Bourne	MA	Massachusetts Natl Cem—Gravesite Expansion & Improvements—Phase 3	20,500,000	2009	15–Jun–13	AA
Calverton	NY	Gravesite Expansion And Columbaria	30,535,000	2009	9–Oct–11	CO
Elwood	IL	Abraham Lincoln Cem—Phase 2 Gravesite Expansion	39,300,000	2010	6–Mar–12	CO
Houston	TX	Gravesite Expansion & Improvements—Phase 4	35,000,000	2010	9–Jan–13	CO
Annville	PA	Indiantown Gap National Cemetery—Phase 4 Expansion	23,500,000	2011	1–Oct–13	CD
Kent	WA	Tahoma National Cemetery—Phase 2 Expansion	25,800,000	2011	30–Dec–13	CD
Los Angeles	CA	Columbarium Expansion	27,600,000	2011	30–Oct–13	CD

Status Codes:
AA—Advertise & Award
AE—Selection of the AE Firm for Design
DD—Design Development
CD—Construction Documents

CO—Construction
S/DD—Schematics/Design Development
MP—Master Plan

Question 21: What are the factors and methodologies currently being considered for identifying activation costs and annual costs of VA facilities?

Response: VA is currently working with contractors to develop a tool that will calculate all in non-recurring and recurring costs for activating VHA facilities, which it expects to incorporate into its Strategic Capital Investment Planning (SCIP) process in the 2013 budget cycle. This model will factor in space type, change in mission, incremental change in workload, locality, estimated construction project costs, square footage, net new FTE, and IT requirements in order to estimate non-recurring and recurring activation costs for IT and total building activation needs. VA will continue to refine its estimates over the course of the construction project using planned equipment lists and FTE estimates as they become available.

Question 22: What will be the detailed recurring annual costs of the new and replacement VA Medical Center facilities, including maintenance and operation?

Response: The detailed recurring maintenance and operation cost of new facilities (major construction) are included in the project prospectus (Chapter 2) of Volume 4 of the VA construction budget submission.

Question 23: Of the 830 underutilized buildings identified by VA in the April 5 hearing, how many are 60 years or older? Of these buildings 60 years or older, how many are leased and how many are owned by VA?

Response: Of the identified underutilized buildings, VA has 662 buildings that are 60 years or older at the end of FY 2010. All are owned by VA.

Question 24: What is the total number of buildings leased by VA? What is the total number of buildings owned by VA?

Response: VA leased a total of 1,629 buildings and owned an additional 5,541 buildings at the end of FY 2010.

Question 25: What plan is in place to speed up final disposition for the underutilized facilities?

Response: Each year, VA identifies candidates for reuse or disposal through the Building Utilization Reuse and Review (BURR) process. The BURR process seeks to reuse underutilized assets where feasible, resulting in a quicker disposition as compared to demolition. In addition, VA has included excess space in the calculation of space gaps in Strategic Capital Investment Planning (SCIP), ensuring underutilized space is properly planned for. This means that facilities must either reuse excess space or have a disposal plan in place, before claiming an additional space need, creating a strong incentive to accelerate reuse and disposal planning. VA has also emphasized both reuse and disposal opportunities in its Real Property Cost Savings and Innovation Plan. In this plan, VA has identified 131 vacant or underutilized buildings to repurpose for homeless housing, 17 buildings to repurpose for other Enhanced-Use Lease initiatives, and 128 vacant or underutilized buildings to demolish or mothball.

Question 26: Do the targeted energy efficiency and cost savings of 30 percent higher than current building standards create higher costs or slower contracting and construction than could otherwise be achieved? What are the targeted energy efficiency and cost savings at other large agencies?

Response: As stated in the Energy Policy Act of 2005, all Federal agencies are mandated to achieve the 30 percent target under the Energy Independence and Security Act (EISA). VA budgets an incremental three to 5 percent of total project costs to achieve this target. No delays in contracting or construction are associated with meeting this target.

Question 27: The VA's Facility Condition Assessment (FCA) report compares the correction cost of buildings in poor or critical condition compared to the total replacement cost of the building. Is there a ratio of those two numbers that definitively decides whether VA will move toward one action or the other, and if so what is that ratio? If there is not a definitive ratio in the FCA report, what are other factors that dictate whether to correct versus replace a facility?

Response: There is no definitive threshold. The final decision between repair and replacement will depend on local conditions, including historic status of the building and the nature of facility space need. However, in general, SCIP Space Analysis rec-

ommends disposal of buildings in which the correction cost of FCA deficiencies is greater than 50 percent of the replacement value of the building.

Question 28: In a report recently submitted to the Committee by the Secretary outlining construction and design contracts not awarded by the end of the last fiscal year, the replacement medical center facility in Denver, Colorado, was referenced. Funds have been appropriated for this project since Fiscal Year 2004, and yet the Phase I demolition was not awarded until April 2009. The report tells the Committee that the "project went from a replacement medical center to a super clinic, then back to a replacement medical center on a *smaller* (emphasis added) scale than the original project." Can you explain to this committee how the planning started with one size, got significantly bigger, then significantly smaller?

Response: Chronology of Events—Planning Studies and Key Decisions Regarding the Denver VA Medical Center

- In 2000–2003, discussions about options for the Denver VAMC began between the Network 19 Director and CEO of the University of Colorado Hospital (UCH). The University of Colorado Health Sciences Center and the University of Colorado Hospital had secured access to the former Fitzsimons Army Medical Center campus through the City of Aurora Redevelopment Authority who took over the campus through the BRAC process. The University announced their long-range plan to completely relocate the Health Sciences Center and the University Hospital to the Fitzsimons campus. During this time frame, several feasibility studies were done to explore a potential partnership between VA and the University of Colorado at the Fitzsimons campus. The general consensus was to proceed in further evaluating options for the Denver VAMC and a possible joint venture with the University of Colorado Hospital (UCH).
- In May 2004, Secretary Principi approved a recommendation to replace the 55-year-old Clermont Street hospital. The Secretary's CARES decision from May 2004 was that the VA "will build a replacement VA medical center through a sharing agreement with DoD on the Fitzsimmons campus with some shared facilities with the University of Colorado."
- In 2005–2007, Secretary Nicholson furthered the development of the actual location site of the replacement hospital on the Fitzsimons campus and secured congressional delegation authorizations and appropriations.
- In January 2008, Secretary Peake was briefed on the status of the new replacement hospital which was a modern, state-of-the-art, regional medical center—with a pricetag of more than $1.1 billion. Concern was raised that building a hospital of such size would not properly serve Veterans outside of the greater Denver area.
- In April 2008, a new plan was developed to build a new Ambulatory Care Center that would have the same number of outpatient clinics as the existing hospital, and was to have a suite for same-day surgeries. The one important difference between the old plan and the new one: instead of VA building its own "bed tower" to house patients who remain in the hospital overnight, we would lease hospital floors from the University of Colorado Hospital. Special areas were to be set aside for a 22-bed nursing home care unit: and Rocky Mountain area Veterans with spinal cord injuries would get a new 12-bed Spinal Cord Injury unit. We were to build two new Ambulatory Centers: one in Colorado Springs and another in Billings and would provide expanded services at existing clinics in Grand Junction, Helena and Cheyenne, and expand home care services and telehealth programs. External stakeholders, however, did not embrace the concept of a "hospital within a hospital" and the concept encountered considerable opposition from external stakeholders and the Colorado congressional delegation.
- In 2009, Secretary Shinseki made the decision to proceed with the construction of a stand alone VA Medical Center in Denver, Colorado and supported other aspects of the VISN 19 Expansion of Services Plan as a strong model of care that will address the challenges of providing quality health care in an accessible and integrated manner. This plan will result in the addition of two Health Care centers—one in Colorado Springs, Colorado and one in Billings, Montana and the addition of ten new sites of care through Rural Health initiatives. The design of this plan is in full alignment with national VA strategic imperatives and will increase access and provision of inpatient and outpatient services for Veterans in their local community.
- In 2010–2011, plans have progressed with the construction of the new stand alone hospital in concert with Secretary Shinseki's vision.

Question 29: Another contract that was not awarded in the expected time pertains to the replacement medical center in New Orleans. The city of New Orleans and the State of Louisiana were expected to transfer the remaining property to VA by early March 2011. Did this transfer happen?

Response: VA acquired all of the land necessary to construct the replacement VA medical center (VAMC) in late April 2011, with the exception of one parcel (the Dixie Brewery) to be used for research space. VA began site preparation work, awarded the first construction change order for Site Surcharging (site dewatering), and began construction in May 2011. Activation of the facility is expected to commence by December 2014.

Question 29(a): Does the transfer mentioned in the report relate to privately-owned property that officials have taken over using eminent domain? How many residents have been displaced because of this project?

Response: VA is not privy to the exact number of residents that have been displaced via either the State of Louisiana using its power of eminent domain or for other reasons. The State acquired and assembled all 194 parcels for the new VAMC, then deeded the property to VA. Before the State acquired the property, there were approximately 208 people living on 63 of the 194 parcels. The State, using its power of eminent domain has acquired 102 parcels (53 residential parcels, 30 commercial parcels, and 19 vacant parcels), while the remaining parcels were acquired through agreed purchase price transactions with the landowners.

Question 30: Please provide a status update on all 10 of the projects listed in that report.

Response: The ten projects are listed below.

DESIGN

1. Louisville, KY—New Medical Facility

Status: Funds for this project were appropriated in fiscal year (FY) 2009. Design cannot be awarded until a final decision can be made on project scope and location. A feasibility study, which highlighted pros and cons associated with site alternatives, and a market survey, which determined potential availability of alternative sites, were completed in FY 2010, but real estate due diligence studies must be completed to facilitate a final programmatic decision. These due diligence studies are currently underway and should be completed in July 2011 to facilitate a September 2011 decision. Negotiations for master planning and design cannot be completed until a site has been selected and if necessary, a site procurement schedule established. Until that occurs, the balance of the design and construction schedule cannot be determined.

2. West Los Angeles, CA—Seismic Corrections of Several Buildings

Status: Funds were appropriated in FY 2009. Contract award for construction documents (CDs) for the various buildings is still anticipated in September 2011. Building 209 is on a separate accelerated schedule aimed at completing the building for homeless Veterans by September 2012. Additional construction funding will be requested in a future budget submission.

3. Brockton, MA—Spinal Cord Injury Center (SCI)/Mental Health Renovation

Status: Funds were appropriated in FY 2010. The audit by the Defense Contract Audit Agency (DCAA) took considerably longer than expected. A contract was awarded in August 2010 to develop conceptual and schematic designs. A CD award is expected to occur no earlier than late fall 2011. Construction funding will be requested in a future budget submission.

4. Bronx, NY—Spinal Cord Injury/Disorder (SCI/D) Center

Status: Funds were appropriated in FY 2009. The audit by DCAA took considerably longer than expected. A contract was awarded in September 2010 to develop conceptual and schematic designs (SDs) for both the parking garage and SCI phases of construction. A kick-off meeting was held in October 2010 for these design phases. The CD contract is anticipated to be awarded no earlier than late summer 2011. Construction funding will be requested in a future budget submission.

5. Canandaigua, NY—CARES New Construction and Renovation

Status: Funds were appropriated in FY 2010. The magnitude and complexity of the project led to a number of changes, and the audit by the DCAA took more than 8 months to complete. A contract was awarded in September 2010 to develop con-

ceptual and SDs for the new community living center, domiciliary, clinic, and other planned renovations to the existing facility. A CD award is expected to occur in May 2012. Construction funding will be requested in a future budget submission.

6. Livermore, CA—Livermore Realignment

Status: Funds were appropriated in FY 2010. Site selection and procurement is ongoing with an anticipated acquisition date in June 2011. VA awarded a contract for SD and design development (DD) with options for construction documents and construction period services in June 2010. VA anticipates the option for DDs to be exercised in November 2011. Completion of new construction will provide swing space allowing renovation of specialty clinics in Palo Alto.

7. Long Beach, CA—Seismic Corrections, Mental Health and Community Living Center (CLC)

Status: Funds were appropriated in FY 2010. Separating the mental health inpatient and outpatient services into two independent facilities, major revisions to the CLC space program, additions of a parking structure and co-generation plant, and designing the CLC to new planning standards have delayed CD award to late summer 2011. Construction funding will be requested in a future budget submission.

8. Perry Point, MD—Replacement CLC

Status: Funds were appropriated in FY 2010. A delay was experienced in the architect-engineer selection process and several modifications were made to the project plan. SD and DD contract negotiations are underway with a contract award scheduled for the third quarter of FY 2011. Construction funding will be requested in a future budget submission.

9. St. Louis, MO—John Cochran Division—New Bed Tower

Status: Funds were appropriated in FY 2010. The authorization for land acquisition was received in April 2010, and the efforts to acquire land on the north and south sides of the existing hospital are not expected to be finalized until 2012. The architect engineer contract award is scheduled for June 2011. Award planned for evaluation of two additional layouts for master plan with SDs, DDs, CDs, and construction period services (CPS) as option items to be exercised at a later date. The outcome of the land acquisition will play a dominant role in the overall direction of the project as well as the project phasing and schedule. Construction funding will be requested in a future budget submission.

10. San Diego, CA—Seismic Deficiency, SCI and CLC

Status: Funds were appropriated in FY 2010. A contract for schematic design and design development was executed in September 2009. Design revisions include co-locating the SCI patients and CLC residents into one facility increasing the number of SCI inpatient beds, increasing the size of the parking structure, and designing the CLC to the new planning standards. The revisions have delayed CD award to late summer 2011.

Question 31: What is the review process when revising a construction project, such as a change in the square footage of the facility?

Response: The current process for construction scope changes includes a review of all increases and decreases to a project's scope along with the associated costs and schedule impacts. These recommended changes are reviewed internally through the Veterans Health Administration's Capital Asset Board, and then a recommendation is sent to VHA leadership for concurrence. If the change is recommended for approval and triggers congressional notification, the notification will occur prior to implementation of the change. Many times these changes arise during the early phases of design. Most medical projects initially receive design funding, and then construction funding is requested in a subsequent fiscal year. Changes are communicated in the budget prospectus when requesting the construction funding.

Question 32: How and by whom are cost analyses conducted and reviewed by the Department when examining facility construction options? What are the contents of these analyses?

Response: VA staff use several methods to conduct cost analyses and they are reviewed by various VA staff throughout the development of a project. At a project's inception, facility staff may conduct market surveys to analyze the cost of new construction, lease, and renovation options. Next, projects are submitted through the SCIP process, via the business case application, for inclusion in the annual budget request and a cost-effectiveness analysis (CEA) template is required. The CEA is a tool used to analyze the cost of the status quo and viable options. The SCIP process

is completed approximately 12 months prior to funds being appropriated for a capital project and possibly several years before a contract is awarded. As a project progresses to the contract award stage further cost analysis is conducted.

Cost is one element in deciding between capital options. VA staff at the facilities in need conduct the first cost analyses and associated assessments when considering whether a VA structure should be leased, renovated, or built new. The first step in deciding which capital solution should be chosen is to establish the type and level of the health care services needed and their appropriate location(s). VA's Health Care Planning Model provides data on the projected Veteran population, demographics, utilization, and access that assist in this determination.

The second step is to determine the best solution to meet the need (including SCIP identified infrastructure gaps) to provide that care—with a new facility, leased facility, renovated facility, or contract care where appropriate. All capital (major, minor, non-recurring maintenance and leases) business case applications are reviewed and prioritized by a Department-wide SCIP Board and approved through the VA governance process.

VA staff (in most cases located at the facility), conduct the first cost analysis and associated assessments when considering whether a VA structure should be leased, renovated, or built new. The preparer of the business case application proposes the alternative (build new, renovate, lease, etc.) that will be used to meet identified gaps. They must also provide additional justification if the most cost effective means is the not chosen option. Factors, such as the need for additional space, the ability to build on medical center campuses or renovate existing buildings, the requirement for quick implementation or flexibility to terminate a contract (leasing versus construction), and duration (short-term vs. long term) of the need, all go into determining the best solution for providing the best quality health care. For example, a medical center campus that is landlocked, with no excess space would need to pursue leasing or contracting out because building on campus or renovating existing space to provide additional care is not feasible. A campus with excess building space or acreage could more easily renovate space or build new space on the campus.

The majority of VA projects are awarded on a firm fixed price basis as a result of full and open competition. As such, a cost analysis is not required for most of our projects as adequate competition determines price reasonableness. In those relatively few cases where a cost analysis is required, however, VA would request that the Defense Contract Audit Agency (DCAA) conduct an audit of the firm's proposal. DCAA has an agreement with VA to do this work on a reimbursable basis. The DCAA audit lends support to the Contracting Officer in determining that a price is fair and reasonable. In addition, we review historical data as a preferred method of conducting our cost analysis along with the support of the Architect-Engineer of record's independent government estimate (IGE). All VA projects have an IGE, which is used to compare cost proposals for determining cost/price to be fair and reasonable.

Question 33: Has VA ever considered using an independent review process to make an unbiased decision given all possible alternatives related to VA facilities? If so, why has this process not been adopted yet?

Response: VA's capital investment processes have in the past been reviewed by outside parties, including the General Accounting Office (GAO), and VA has been regarded as one of the leaders of these processes in the Federal Government. The Department of Defense's Health Affairs Capital Investment Planning process is in part modeled after VA's process. We would welcome a review by GAO and other independent parties and would embrace any recommendations on how to improve our SCIP process. VA is responsible and accountable for making decisions related to the delivery of health care and benefits services to Veterans. This includes deciding the best means or facility type (construction, lease, etc.) to provide the services. VA's current process ensures projects, along with their possible alternatives, are reviewed and approved at the facility level, and the VISN level prior to being submitted to a Department-wide Panel and Board who evaluate the projects against a standardized set of weighted decision criteria. That evaluation results in a prioritized listing of capital projects used to develop the annual budget request, which is reviewed and approved by the Secretary. Half of the 18 decision criteria are directly related to how much of a service gap a project will fill. The gap data on access, utilization, facility condition, energy gaps, space, etc. that is provided to project developers to guide their decisions on possible alternatives, is used to justify the need for a capital project and is unalterable. In addition, the decision on which type of capital to request to fulfill a need is based on several other factors, such as the ability to build new space or renovate existing space on campus, or the need

for the flexibility to terminate a lease contract on short notice, or the availability of private sources to provide services.

Question 34: What are VA's plans to reduce the $9.4 billion backlog in repairs?

Response: Repair projects are prioritized along with other capital investments. Most are funded by the VHA medical facilities account—non-recurring maintenance (NRM) program. In addition, new major and minor construction projects may also include components that address facility repair needs.

VA has invested a significant amount in recent years to repair existing facilities and building systems. From fiscal years (FY) 2009 through 2011, NRM funding has totaled $4.6 billion. NRM funding for the last 3 years includes:

FY 2009 (Actual)—$1.6 billion
FY 2010 (Actual)—$1.9 billion
FY 2011 (Estimate)—$1.1 billion

VA will continue to invest in meeting facility condition deficiency needs, especially those that have a direct impact on patient safety. The SCIP plan provides (for the first time) a 10-year plan (including specific projects and out-year requirements) to close the 95 percent backlog in facility condition deficiency-related projects.

Question 35: The Capital Asset Realignment for Enhanced Services (CARES) process identified a gap in inpatient care in Far South TX. However, the CARES Commission did not recommend constructing a small VA hospital in this region because: a single location would not accommodate the dispersed veteran population; the low volume need could not support a full range of specialty care; and veterans would still be required to travel to the San Antonio Veterans Affairs Medical Center for specialty care. CARES did recommended constructing a large specialized outpatient health care center (HCC) in collaboration with the University of Texas Regional Academic Health Center and establishing contracts with the large well-regarded multi-specialty private hospitals for inpatient care in the region. In January of this year, VA opened a new Health Care Center (HCC) at Harlingen, TX. However, some stakeholders remain concerned that an inpatient VA medical center in Far South Texas is essential. Did the Strategic Capital Investment Planning (SCIP) process evaluate the need for an inpatient VA hospital in Far South Texas? If so, please provide details as to the outcome of the SCIP evaluation. Additionally, please provide VA's views on the sufficiency of the existing infrastructure and services in Far South Texas to meet the current and future demand for veterans' health care and any recommendations for the need for enhanced services.

Response: The SCIP process and Plan includes evaluating the need for inpatient services at all Veteran Integrated Service Networks (VISNs) and meeting them within the SCIP 10-year time frame. The projected inpatient beds for Far South TX continue to support the current process of contracting inpatient care to the community; this is the most cost effective and advantageous to the government. Therefore, a new inpatient hospital in Far South Texas is not needed. To construct a hospital, the inpatient demand would need to increase significantly to ensure the safety of our patients through maintaining competency levels of staff, and to attract high quality providers in a competitive, professional environment.

The new Harlingen clinic was sized and subsequently constructed based on the projected workload, so sizing and infrastructure deficiencies should be minimal for several years. The new addition to the clinic enhanced the existing services of Primary Care, Audiology, Dental, Dermatology, Physical Therapy, Orthotics, Podiatry, Mental Health (PTSD), Diabetic Retinal Imaging, Radiology and CT Scans, Pulmonary, Ophthalmology, and Spinal Cord Injury Primary Care. The addition created space for Ambulatory Surgery, Cardiology, Pulmonology and Addiction Therapy. Other services are either contracted with the University of Texas or offered at the San Antonio VA Medical Center.

Committee on Veterans' Affairs
Washington, DC.
May 6, 2011

The Honorable Eric K. Shinseki
The Secretary
U.S. Department of Veterans Affairs
Washington, DC 20420

Dear Secretary Shinseki:

In reference to our Full Committee hearing entitled "Deconstructing the Department of Veterans Affairs Construction Planning," that took place on April 5, 2011, I would appreciate it if you could answer the enclosed hearing questions by the close of business on May 27, 2011.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all full Member and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Debbie Smith by fax at 202–225–2034. If you have any questions, please call 202–225–9756.

Sincerely,

BOB FILNER
Ranking Democratic Member

CW:ds

The Honorable Bob Filner, Ranking Member, House Committee on Veterans' Affairs
"Deconstructing the Department of Veterans Affairs Construction Planning"
April 5, 2011

Question 1: To what extent does SCIP define VA's overarching, national strategy for its capital investments?

Response: The Strategic Capital Investment Planning's (SCIP) approach to capital programs reflects VA priorities and good stewardship of resources to maximize benefits and services to Veterans. SCIP demonstrates effectiveness and accountability by developing a comprehensive review of requirements and prioritizing consolidated construction needs across all VA organizations. VA's capital program is driven by the strategic direction embodied in SCIP—to close performance gaps and provide sufficient capital to ensure Veterans receive the best service in facilities that are:

- Safe and secure;
- Located closer to where Veterans live;
- Modern and state-of-the-art;
- Capable of supporting the demand for services and benefits; and
- Able to serve homeless Veterans through use of vacant facilities.

Question 2: When did VA complete its most recent gap analysis, including facility condition assessments, of its capital investment and what were the results?

Response: VA completes annual gap analyses for the SCIP process. The analysis for FY 2012 was completed in January 2010. Each gap area represented in SCIP, such as space or condition, has an analysis performed in support of the annual process. For example, condition assessments are completed throughout the year and summarized in the annual gap analysis. Other gap areas, such as space and energy, are tracked throughout the year and the final end of year numbers are used to perform the gap analysis. The results of the analysis performed for the SCIP process are represented in VA's FY 2012 budget for each gap area, by Administration (Veterans Health Administration, Veterans Benefits Administration, National Cemetery Administration). The SCIP plan and other VA Budget documents can be found on the Department's Web site at http://www.va.gov/budget/products.asp

Question 3: To what extent does SCIP define the gaps in meeting its capital investment needs?

Response: The SCIP process is gap-driven, such that all capital investments are scored and prioritized based on the type and criticality of the gaps closed. The outputs of SCIP are projects that address the most critical gaps first, with additional projects in out-years to address the remaining gaps. SCIP includes gap areas that affect the needs for capital investment, including but not limited to, safety, security, space, condition, energy efficiency, IT-related infrastructure, workload, access, and functional gap areas. Although it is possible there may be a capital need that addresses a gap not included in SCIP, VA believes it has captured the majority of key drivers for capital investment as part of the gap analysis process. Any additional needs identified may be merged into the SCIP process as it continues to mature.

Question 4: What are VA's plans to reduce the $9.4 billion backlog in repairs?

Response: Repair projects are prioritized along with other capital investments. Most are funded by VHA's medical facilities account—non-recurring maintenance (NRM) program. In addition, new major and minor construction projects may also include components that address facility repair needs.

VA has invested a significant amount in recent years to repair existing facilities and building systems. From fiscal years (FY) 2009 through 2011, NRM funding has totaled $4.6 billion. NRM funding for the last 3 years includes:

FY 2009 (Actual)—$1.6 billion
FY 2010 (Actual)—$1.9 billion
FY 2011 (Estimate)—$1.1 billion

VA will continue to invest in meeting facility condition deficiency needs, especially those that have a direct impact on patient safety. The SCIP plan provides (for the first time) a 10-year plan (including specific projects and out-year requirements) to close the 95 percent backlog in facility condition deficiency-related projects.

Question 5: What is VA doing to address challenges in managing its real property, such as improving its project cost estimates?

Response: The SCIP plan states that action plans will contain magnitude cost estimates based on a "snapshot" in time. Project costs are refined and improved as the project moves along in the budget process—beginning with the magnitude cost found in the action plan, refined at the business case submission, and later through the detailed OMB 300 business case. The estimated costs are improved and provided in the project prospectus in the budget submission and may be updated again at completion of project design. VA is also working to develop a methodology for including activation (project estimated start-up cost) in future SCIP plans beginning with the SCIP 2013 submission.

Question 6: How long does VA estimate it will take to complete the major and minor construction projects that are ongoing?

Response: There are currently 23 partially funded major construction projects that total approximately $6 billion with remaining need. In order to maximize resources, VA requests funds for phased major projects based on the project's schedule and its ability to obligate in the request year. The level of major construction funding provided will have a critical and direct impact on the time it takes to complete all ongoing projects. VA anticipates a large majority of partially funded minor construction projects will be obligated by the end of FY 2012.

Question 7: What is the percent weighting factor for reducing excess property that VA used to evaluate projects?

Response: Capital projects were evaluated on 18 distinct sub-criteria for the FY 2012 SCIP process, several of which apply to a project that reduces excess property. Two sub-criteria focus specifically on reducing excess property, *Space—Repurposing* and *Space—Demolition,* each of which are valued at a maximum of 1.2 percent of the project score. Repurposing and Demolition sub-criteria are part of the Right-Sizing Inventory major criterion that is ranked fifth out of the six major criteria. Another component of the project score is the rating factor applied to each sub-criterion. The factor applied to both the Repurposing and Demolition sub-criteria is the percentage of the gap filled. Not all projects will earn a rating of 1 (the highest possible rating) for these sub-criteria.

A project that reduces excess space can earn points for various other sub-criteria. For example, a project that reduces excess property could also receive points for any combination of the following sub-criteria: Safety/Compliance (10.9 percent); Seismic

(11.4 percent); Supporting Initiatives (3.3 percent); Energy Standards (3.9 percent); Best Value Solutions (3.6 percent); and Maximize Efficiencies (1.2 percent). Percentage values represent the maximum point value.

Question 8: GAO's recent report on VA real property did not assess the extent to which the results of SCIP are reflected in the President's fiscal year 2012 budget. How does SCIP respond to GAO's recommendation to provide the results of your capital planning efforts, including details on the estimated cost of all future projects, to Congress on a yearly basis?

Response: The SCIP plan lists the projects to be addressed in FY 2012. It also details the projects (including location, description, and estimated cost) and other investment levels needed to meet gaps for fiscal years 2013–2021. Specific projects and associated estimated costs can be found in volumes 4 and 5 of the Department's FY 2012 budget submission (http://www.va.gov/budget/products.asp).

Question 9: How will VA measure the effectiveness of SCIP, and how will VA inform Congress of its effectiveness?

Response: The SCIP process determines the investments needed to address gaps in space, access, safety, facility condition, efficiencies, and utilization. SCIP does not guarantee that VA will receive all the funding needed to close these gaps. Therefore, the current metrics used to measure effectiveness are primarily process-focused. For example, a key measure was the prioritized list of projects and 10-year SCIP plan delivered on-time along with the Department's budget. Other measures that are tracked include the number of VA staff who are trained on important SCIP elements and requirements, and the percentage of projects in budget execution that were reviewed during the SCIP process. In the future, once projects are funded, constructed and in use, VA will be able to measure their impact on the various SCIP-identified gaps. Measured results will be included in future VA budget submissions.

Committee on Veterans' Affairs
Washington, DC.
May 6, 2011

The Honorable Gene L. Dodaro
Comptroller General
U.S. General Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Comptroller General:

In reference to our Full Committee hearing entitled "Deconstructing the Department of Veterans Affairs Construction Planning," that took place on April 5, 2011, I would appreciate it if you could answer the enclosed hearing questions by the close of business on May 27, 2011.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all full Member and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Debbie Smith by fax at 202–225–2034. If you have any questions, please call 202–225–9756.

Sincerely,

BOB FILNER
Ranking Democratic Member

CW:ds

U.S. Government Accountability Office
Washington, DC.
May 26, 2011

The Honorable Bob Filner
Ranking Member
Committee on Veterans' Affairs
House of Representatives

Subject: *Responses to Post Hearing Questions for the Record; Committee on Veterans' Affairs, April 5, 2011, Hearing on "Deconstructing the Department of Veterans Affairs Construction Planning"*

Dear Mr. Filner:

This letter responds to your May 6, 2011, request that we address questions submitted for the record related to the April 5, 2011, hearing entitled, *Deconstructing the Department of Veterans Affairs Construction Planning.* Our answers to the questions are enclosed and are based on our previous work, updates to that work, and our knowledge of the areas addressed. Our previous work was conducted in accordance with generally accepted government auditing standards or GAO's quality assurance framework. Because our responses are based in large part on previously issued products for which we sought and incorporated agency comments, we did not seek agency comments on our responses to these questions.

If you have any questions or would like to discuss our response, please contact me at (202) 512–2834 or stjamesl@gao.gov.

Sincerely yours,

Lorelei St. James
Acting Director, Physical Infrastructure Issues

Enclosure

Response to Post Hearing Questions for the Record
Deconstructing the Department of Veterans Affairs Construction Planning
April 5, 2011

Questions Submitted by the Honorable Bob Filner, Ranking Member, Committee on Veterans' Affairs, U.S. House of Representatives
Questions for Lorelei St. James, Acting Director, Physical Infrastructure Issues
U.S. Government Accountability Office (GAO)

Question 1: What other actions could the Department of Veterans Affairs (VA) consider to ensure better management of its real property portfolio?

Response: As we testified during the hearing before your committee on April 5, 2011, GAO has been looking at this topic for decades and has made a number of recommendations over the years.[1] For example, in 2008, we reported that while VA had made significant progress in reducing underutilized and vacant property, the agency does not track how much it costs to maintain these properties or which authorities, such as enhanced use leases, were most effective in property reduction.[2] As such, we recommended that VA develop an annual cost estimate for how much it spends on underutilized and vacant property and develop a way to track, monitor, and evaluate which authorities were most effective at reducing it. VA concurred and has taken steps to implement this recommendation. In an effort to review what costs can and should be applied to supporting underutilized and vacant property, VA told us it analyzes operational cost data to determine actual cost to operate per square foot and has developed annual costs to maintain vacant and underutilized properties at the individual building level. In our 2009 report on VA construction,[3]

[1] GAO, *VA Real Property: Realignment Progressing, but Greater Transparency about Future Priorities Is Needed,* GAO–11–521T (Washington, D.C.: April 5, 2011).

[2] GAO, *Federal Real Property: Progress Made in Reducing Unneeded Property, but VA Needs Better Information to Make Further Reductions,* GAO–08–939 (Washington, D.C.: September 10, 2008).

[3] GAO, *VA Construction: VA is Working to Improve Initial Project Cost Estimates but Should Analyze Cost and Risk Schedules,* GAO–10–189 (Washington, D.C.: December 14, 2009).

we recommended that VA improve its cost risk analysis through the use of an integrated construction schedule and a schedule risk analysis.[4] According to VA, this recommendation is partially implemented and will be fully implemented in fiscal year 2011. More recently, in our 2011 report on VA real property, we found that even though VA's capital planning efforts led to realignment of its real property portfolio, more transparency about the cost of future priorities could enhance decision-making.[5] As a result of this finding, we recommended that VA annually provide to Congress the full results of SCIP and any other subsequent capital planning efforts, including details on estimated cost of future projects. In our response to question 2 of this enclosure, we further discuss the implementation of this recommendation. GAO publicly reports on agency progress in implementing recommendations and will continue to monitor and follow up on the implementation of the recommendations made to VA on these matters.

Question 2: What actions can VA take to strengthen its Strategic Capital Investment Planning (SCIP) or other capital investment planning processes?

Response: In our 2011 report, we determined that VA could continue to follow leading capital planning practices by ensuring that SCIP is linked to its Strategic Plan.[6] Further, we recommended that VA provide the full results of its SCIP or other capital planning processes to Congress on a yearly basis. VA concurred and recently updated GAO on its initial efforts to implement this recommendation.

In its fiscal year 2012 congressional budget submission, we found that VA provided its SCIP results and its 10 year capital plan.[7] The 10-year plan included the following details:

- fiscal year 2012 and potential future projects through fiscal year 2021 with their estimated costs;
- projects and cost estimates, sorted by investment type (e.g., major construction, leases, minor construction, non-recurring maintenance), location and prioritized rankings; and
- a description of the SCIP process and methodology, including the criteria by which projects are evaluated and prioritized.

Regarding efforts to strengthen SCIP, VA acknowledges that its current estimates do not include activation costs. As such, VA stated that it plans to develop a methodology to allow for the incorporation of activation costs for future SCIP plans and we agree that this, too, could strengthen SCIP and its results. While we reviewed VA's budget submission, we did not validate VA's SCIP results. Further, VA's current 10-year plan does not clarify how the agency plans to evaluate and measure the validity of its capital planning results. Given VA's effort to effect a large scale transformation of its real property portfolio and the substantial capital investment these efforts will require, we agree that capital planning is an especially important area for VA. Further, measuring the success of VA's capital planning efforts, such as SCIP, is critical in understanding the impact of capital planning decisions and the extent to which real property changes have helped improve service to veterans. Beyond these observations, we would need to do additional work, focused on VA's progress with SCIP, to identify additional actions that could be taken.

Question 3: Regarding real property management, what can VA do to better close the gaps in veterans' care needs?

Response: Also in our 2011 report, we identified that VA, in an effort to meet veterans' needs, could continue to ensure that its gap analyses are linked to areas needed as outlined in its Strategic Plan. For example, VA conducts gap analysis on access, utilization, space, and condition of its real property and reports the results

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[4] An integrated master schedule should be horizontally and vertically linked. The schedule should be horizontally integrated, meaning that it should link the products and outcomes associated with already sequenced activities. The schedule should also be vertically integrated, meaning that traceability exists among varying levels of activities and supporting tasks and subtasks. A risk analysis should include a determination of the largest risks to the project, a plan for mitigating those risks, and an estimate of when the project will be finished if the risks are not mitigated.

[5] GAO, *VA Real Property: Realignment Progressing, but Greater Transparency about Future Priorities Is Needed,* GAO–11–197 (Washington, D.C.: Jan. 31, 2011).

[6] GAO–11–197.

[7] *The Department of Veterans Affairs: FY 2012 Budget Submission Construction and the 10-year Capital Plan, Volume 4 of 4* (Washington, D.C.: February 2011).

in its annual budget submission.[8] VA could also continue to explore alternatives to dispose of excess property and better use underutilized space, with initiatives such as enhanced use leasing,[9] VA/DoD collaborating & sharing,[10] and addressing veteran homelessness.[11]

Question 4: To what extent does SCIP better equip VA to address the current backlog of maintenance, approximately $9.4 billion as reported in VA's 5-year capital plan for fiscal years 2010–2015?

Response: As a part of SCIP, VA centralized its prioritization of capital projects across all of its administrations (VHA, NCA, and VBA) and staff offices. SCIP resulted in a single, prioritized list of projects for all of VA's major construction and minor construction, leases, and non-recurring maintenance projects for fiscal year 2012. Potential future projects, including non-recurring maintenance, are also listed in the 10-year plan. While the potential project list in the 10-year plan includes estimated costs, those projects are not prioritized. To comment further on how SCIP could better equip VA to address its maintenance backlog, we would need to do additional work to more comprehensively assess the impact of SCIP, as it was relatively new when we performed the work for our January 2011 report.

Committee on Veterans' Affairs
Washington, DC.
May 6, 2011

Raymond C. Kelley
Director, National Legislative Service
Veterans of Foreign Wars
200 Maryland Avenue, NE
Washington, DC 20002

Dear Ray:

In reference to our Full Committee hearing entitled "Deconstructing the Department of Veterans Affairs Construction Planning," that took place on April 5, 2011, I would appreciate it if you could answer the enclosed hearing questions by the close of business on May 27, 2011.

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Due to the delay in receiving mail, please provide your response to Debbie Smith by fax at 202–225–2034. If you have any questions, please call 202–225–9756.

Sincerely,

BOB FILNER
Ranking Democratic Member

CW:ds

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[8] For its gap analysis, VA defines each type of gap as follows: (1) Access Gap is the ability of Veterans to obtain needed services within a defined geographical area, as defined by drive-time or distance; (2) Utilization Gap is the difference between current workload and projected 2018 demand for outpatient clinic stops and inpatient bed days of care; (3) Space Gap is the difference between current space inventory and projected 2018 space need; and (4) Condition Gap is the cost estimate to correct all currently identified deficiencies in buildings and infrastructure.

[9] Enhanced-use leases are typically long-term agreements with public and private entities for the use of VA property, resulting in cash, in-kind consideration, or both. VA is authorized to enter into an enhanced-use lease if it enhances the use of the property or results in an improvement of services to veterans in the network in which the property is located.

[10] VA states that the fiscal year 2003 Defense Authorization Act (Public Law 107–314, Section 721) required VA and DoD to establish a joint incentive program to identify, evaluate and fund local, regional, and national sharing initiatives.

[11] VA has made an effort to repurpose unused VA properties for the development of new housing opportunities for veterans and their families.

VFW response to the Honorable Bob Filner regarding questions concerning the April 5, 2011 "Deconstructing the Department of Veterans Affairs Construction Planning" hearing

Question 1: Given that VFW does the construction portion of the Independent Budget (IB), to what extent was your organization involved in the development of the SCIP process? In other words, were you actively involved and asked for input or were you simply given updates through a briefing or some other form of communication once decisions were made?

Response: No. VFW was not involved in the development of the SCIP process. However, the process closely resembles widely accepted capital asset management methods. The main difference between the capital plans is how they determine the urgency of repair. Commercial capital plans appear to base their decisions on usability while VA places more weight on safety while scoring capital priorities. I believe that the only place that VA could have sought input from VSOs would have been the scoring process through the six criteria that is used to determine the final ranking of asset gaps. Even though VSOs were not included in that process, VFW would not have weighted the process any differently.

Question 2: The Independent Budget (IB) supports levels for minor and major construction well above the amounts recommended by the President's Budget. Please expand on your rationale for this recommended increase.

Response: *The Independent Budget* (IB) minor construction accounts are very comparable to those of the Administration. The main difference in the levels can be found in the NCA construction accounts. The IB requests funding to complete all partially funded construction projects in FY 2012, while VA's plan takes multiple years to complete current projects.

The defining difference between the IB recommendation and VA's requested funding levels in Major construction is in the amount of time that should be allowable to complete a partially funded project. VFW and the IB believe that no major project should take more than 5 years to fund. VA's FY 2012 plan funds most of its projects at a level that will only pay 10 percent of the needed funding. If this level of funding continues and VA is serious about following SCIP, they will need to fund at a much higher level to fulfill the capital asset gaps that have been identified.