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DRAFT BILL, THE DEPARTMENT OF VETERANS AFFAIRS REAL PROPERTY AND FACILITIES MANAGEMENT IMPROVEMENT ACT

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTH CONGRESS

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DRAFT BILL, THE DEPARTMENT OF VETERANS AFFAIRS REAL PROPERTY AND FACILITIES MANAGEMENT IMPROVEMENT ACTOF 2004

THURSDAY, JUNE 24, 2004

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

The subcommittee met, pursuant to notice, at 9:30 a.m., in room 334 Cannon House Office Building, Hon. Rob Simmons (chairman of the subcommittee) presiding.

Present: Representatives Simmons, Moran, Miller, Bradley, Beauprez, Brown-Waite, Rodriguez, Snyder, Berkley, and Ryan.

OPENING STATEMENT OF CHAIRMAN SIMMONS

Mr. SIMMONS. The hearing will come to order.

This is a legislative hearing on a draft bill, the Department of Veterans Affairs Real Property and Facilities Management Act of 2004. I am happy to welcome all our witnesses, but in particular I am glad to see my friend and former colleague over on the Senate side as a staffer and fellow Vietnam veteran that is with us today, the very distinguished and honorable Secretary of Veterans' Affairs, Secretary Principi. Good to have you here.

And I think he is joined by Mr. Alvarez, also a Vietnam veteran, who spent a number of years in that country under circumstances that most of us would probably not want to share but circumstances that earned him the Silver Star, the Distinguished Flying Cross, and is one of the great stories of heroism. Welcome to you, Mr. Alvarez, a pleasure to have you here.

The purpose of today's legislative hearing is to consider draft legislation to authorize the Secretary to enter into certain capital leases, establish new procedures for transferring VA properties no longer needed for the care of veterans, and to create a new fund into which proceeds from such transfers would be deposited.

In recent years, the Veterans Administration investment in its health care facilities has fallen below known needs. And the reason for this is the VA has been reluctant to commit large capital investments until the Capital Asset Realignment and Enhanced Services process was completed so we could avoid spending funds on facilities that would be determined no longer needed in the future. And I say to my friends on the subcommittee and to those listening to this hearing the long dry spell is over. In May of this year, the Sec-

retary adopted a CARES plan and it is being described as the VA roadmap for health care for the next 20 years.

Beginning this year and continuing forward the VA plans to award contracts for 30 major projects at an estimated $1 billion, spending an additional billion each year for the next 5 years to get VA's infrastructure back up to where we want it to be. It is my understanding that VA plans to re-evaluate project priorities each year as we go along and make appropriate adjustments which I personally welcome.

Let the record show that Public Law 108-170 Congress has delegated to the Secretary the authority to select and move forward on capital projects within certain conditions in fiscal years 2005 and 2006. And so we will return to the regular order of authorization of each major project through an act of Congress. The VA has a good opportunity to move forward with some efficiency and we look forward to seeing this happen. In particular, I know in my state, the West Haven VA Medical Center is in dire need of renovations, and we look forward to working on that project, as well.

Many VA community clinics operate in privately-owned facilities. Unfortunately, Public Law 108-170 did not provide the Secretary authority on execution of capital leases. That is those costing $600,000 or more annually. The VA identified the need for authorization or renewal of 17 of these capital leases and the draft bill before the committee would authorize the leases in the recommended locations. The bill would also authorize the Secretary to enter into a long-term lease of up to 75 years for land to construct a new combined medical facility on the Fitzsimons Campus of the University of Colorado in Aurora, CO, a tremendous facility that has been very much the brain child and the focus of our colleague from Colorado, Mr. Beauprez. And I understand he will have a few comments to make on that at an appropriate time.

The bill would also provide the Secretary with an additional authority to transfer unneeded real property currently in VA's portfolio and would repeal the defunct nursing home revolving fund, replacing it with a capital asset fund. And the dollars going into that fund would defray the VA's cost of transferring real property. The bill would include a provision to permit the construction of surface parking and would exempt the VA from state and local land use or zoning laws.

Finally, it would extend VA's authority to provide care to the veterans participating in special long-term care demonstration projects, previously authorized in the Veterans Millennium Health Care and Benefits Act. This is a very comprehensive piece of legislation. It is a very appropriate piece of legislation. It is legislation that grows out of a very comprehensive and very interesting and exciting report entitled, "CARES Decision." And I look forward to hearing all of our witnesses testify on these subjects.

At this point, I would like to defer to my colleague and friend from Texas, Mr. Rodriguez, and ask him if he has comments that he would like to make for the record.

OPENING STATEMENT OF CIRO D. RODRIGUEZ

Mr. RODRIGUEZ. I thank you, Mr. Chairman. Mr. Chairman, this hearing covers a lot of ground and many of the important issues

which we must address as we consider authorizing significant improvements in the Veterans Health Administration infrastructure.

I am pleased to welcome Secretary Principi, who will share the VA's views on some of these important issues. Welcome, Mr. Secretary. And I am also pleased that Chairman Alvarez is here to represent the Commission on Capital Asset Realignment for Enhanced Services, CARES, and share with us some things about the process the Commission used in the recommendations that it made. Welcome.

I have previously referenced some of my concerns about CARES and the strategic planning affecting infrastructure decisions for veterans. I am certain others share my views about the absence of long-term care and mental health planning in the CARES process and how failure to adequately address veterans' needs for these two important programs might have affected the outcome of the process. I find it somewhat ironic that although these programs were reportedly off the table in making recommendations for the infrastructure, the facilities that house such programs seemed particularly prone to significant downsizing or closure.

In addition, I remain with concerns about rural veterans throughout this country and the access to adequate services under the CARES process. CARES does little to address veterans' access to acute hospitalization in the southern part of Texas, which includes not necessarily my district but a couple of other Members of Congress in south Texas, and I know that there are many others in rural America who also share the same concerns. I understand that the VA assigned a task force to develop guidance for what it has termed Veterans Rural Access to Hospitals. I understand its work was due to be completed at the beginning of this month, and I hope the Secretary will be able to share more information on the recommendations the VA will make for these types of providers today.

I am also unclear about the extent to which the VA considers the needs of future veterans or increased enrollment in this strategic planning models, since we know the demographics and the number of our veterans that are out there. With the hundreds of thousands of service members that will be involved and deployed not only in Iraq but as well as in Afghanistan and elsewhere, this must clearly be a concern of all of us and of the Congress.

In sequencing our investments in infrastructure, it is also absolutely imperative to ensure that if closures are recommended, that replacement facilities are readily available to pick up the workload that will be lost.

Since the CARES planning exercise affects so many veterans around the nation, I asked Members of Congress that had previously contacted the committee to share their views with us on these planning processes and the concerns that they might have. I have asked the chairman that I be allowed the opportunity to receive their statements. Mr. Chairman, I ask that the additional statements be included into the hearing record.

Mr. SIMMONS. Without objection, so ordered.

Mr. RODRIGUEZ. Thank you, Mr. Chairman. I am also interested to hear the VA's views on discussing drafts that the chairman has offered for our review. I know that the VA has requested many of

these authorities and will be eager to hear the Department's rationale about waiving some of our federal laws in order to establish a fund to renovate some of the VA under used facilities. There are many aspects of this bill I can readily support and there are several leases for enhanced community-based outpatient clinics in not only South Texas but throughout the country that are good.

While the clinics the VA has identified will not address access to acute hospital care, the real access problems for the veterans in my district, I certainly appreciate the needs for the clinics in my area. And I will plan to work closely with you, Mr. Chairman, to make sure that we move forward on this.

I am also supportive of the need to continue some of the pilot programs that we authorized under the Millennium Health Care and Benefits Act of 1999. While we do not yet have all of the information about the pilot programs, I certainly agree that veterans who have benefitted from these programs should also be able to continue to receive these services.

In the meantime, I hope that the VA plans to make the required reports available to Congress so that we can make informed decisions about the expanding and comprehensive care of management services as well as assisted living to elderly veterans.

And, once again, Mr. Secretary, Mr. Alvarez, thank you for being here with us. I look forward to your testimony. Thank you.

Mr. SIMMONS. As I mentioned in my opening statement, one of the major projects that is considered by this legislation is the Fitzsimons project in Aurora, CO. I have received a special request from our colleague, Mr. Beauprez, who represents that area, if he could have an opening statement. Is there any objection to that?

Ms. BERKLEY. I won't object as long as I can have one, too.

[Laughter.]

Mr. SIMMONS. I knew that was what was going to happen. Mr. Beauprez, you may proceed with your opening statement.

OPENING STATEMENT OF HON. BOB BEAUPREZ

Mr. BEAUPREZ. Thank you, Mr. Chairman. And I thank the Congresswoman from Nevada. Thank you, Mr. Chairman, first of all, for holding this hearing. I am sure you can appreciate the anticipation I have had for this hearing. It is a special day. If the needs of our veterans continue to grow, it is certainly important to the VA to make intelligent investments in their infrastructure. And as you very well know, the needs of our veterans are all too often at odds with our ability to meet them. This makes it especially important for the agency to modernize its facility as well as its processes and procedures. Mr. Chairman, I know that you share my commitment to providing the very best care to our veterans, and I believe the CARES plan establishes a very solid roadmap for the accomplishment of that goal.

It is certainly great to see our wonderful Secretary Principi again today. Chairman Alvarez, it is good to have you with us and other members of your staff, Mr. Secretary. I am especially happy and eager to hear the testimony of my good friend Dennis Brimhall, president of the University of Colorado's Hospital and one of the chief architects of this exciting collaboration between the Univer-

sity of Colorado, the Department of Veterans Affairs, and the Department of Defense.

I believe the partnership at Fitzsimons is and will continue to be a model for the rest of the country in the way we deliver health care to our veterans. By combining resources and taking advantage of economies of scale, all of the partners in this exciting project are winners, but most importantly, Mr. Chairman, the veterans who will be served by the new VA hospital at Fitzsimons, will be the biggest winners of all.

I look forward to the testimony of today's witnesses and to finding better ways to effectively and efficiently deliver services that American veterans have earned.

And with that, I yield back. Thank you, Mr. Chairman.

Mr. SIMMONS. Thank you. Do any other members of the subcommittee wish to make an opening statement? Ms. Berkley?

Ms. BERKLEY. Thank you very much. Thank you, Mr. Chairman. For 5 years, this committee, and anyone else within the sound of my voice, has heard about the plight of my veterans in southern Nevada. As you all know, I am well aware of I have got the fastest-growing veterans population in the United States there. It is about 200,000-plus.

Mr. SIMMONS. I think we have heard about that at least once.

OPENING STATEMENT OF HON. SHELLEY BERKLEY

Ms. BERKLEY. With no facilities. We had an outpatient clinic that was condemned as structurally unsound after only 5 years of service. I have got 80-year-old veterans standing on the corner waiting for a shuttle to pick them up, because as the alternative to that outpatient clinic, when it was condemned and closed, is that we now provide outpatient services at 10 different locations throughout the Las Vegas Valley, which means that I have a lot of oldsters and handicapped veterans standing in 110 degrees temperature waiting for a shuttle to pick them up to shuttle them from one location to the other. As you know and can feel, I am sure, that is totally inappropriate and unconscionable.

In May, I had the honor to be in my district with Secretary Principi as he announced the final CARES initiative, which includes a long-awaiting full-service hospital, outpatient clinic, and comprehensive long-term care nursing home facility in southern Nevada. And I cannot express sincerely enough my thanks to the Secretary for hearing my pleas, being sensitive to the veterans that I represent, and making that medical complex in southern Nevada on his list of construction priorities. I am encouraged that the veterans in southern Nevada will soon have access to health care services they have earned.

And I urge the VA, and I think this is my message, to expedite the planning and construction process for this medical complex so all health care services will be available to the veterans in southern Nevada from World War II veterans in need of long-term care to a new generation of veterans returning home from fighting overseas. And I cannot emphasize enough how much courage it took for the Secretary to do this.

This CARES study was exhaustive. And I know that there are some colleagues that are unhappy because some of their facilities

are closing, but I can assure you the Southwest, which is the fastest-growing part of our nation, is in dire need of these facilities because that is where the veterans are living. And it makes no sense to me, and I think the CARES study pointed out the fact, that we have a number of facilities located in one community that has a handful of veterans left, and those of us in the western United States that have thousands and thousands of veterans are undercared for and under-served. So I want to thank him again for having courage and strength of conviction. I know it is difficult to close facilities.

And let me say since I come from a gambling town, we have a lot of superstitions, you know. You are not supposed to walk past a slot machine from the back instead of the front. And seven is a very lucky number. And I just want to share with you that you made this announcement in Las Vegas on May 7 and we are number seventh on your priority list. So this a really banner day for Las Vegas and the veterans that live there. And I want to thank you from the bottom of my heart.

Mr. SIMMONS. Do any other members wish to make an opening statement? Hearing none, it is my pleasure, again, to introduce the Honorable Anthony J. Principi, Secretary of the Department of Veterans Affairs, who will be our principal witness, accompanied by the Honorable Tim S. McClain, general counsel; Honorable William H. Campbell, assistant secretary for management; Dr. Laura Miller, deputy under secretary for health operations and management; and Mr. Jim Sullivan, deputy director, Office of Asset Enterprise. Also at the table is our very distinguished former chairman of the Capital Asset Realignment for Enhanced Services Commission or CARES Commission, the Honorable Everett Alvarez, Jr. Gentlemen and lady, thank you so much for coming here today. We are obviously very, very interested in the topic and we look forward to your testimony.

Mr. Secretary?

STATEMENTS OF THE HONORABLE ANTHONY J. PRINCIPI, SECRETARY, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY TIM S. MCCLAIN, GENERAL COUNSEL, DEPARTMENT OF VETERANS AFFAIRS; WILLIAM H. CAMPBELL, ASSISTANT SECRETARY FOR MANAGEMENT, DEPARTMENT OF VETERANS AFFAIRS; LAURA MILLER, DEPUTY UNDER SECRETARY FOR HEALTH FOR OPERATIONS AND MANAGEMENT, DEPARTMENT OF VETERANS AFFAIRS; AND JAMES M. SULLIVAN, DEPUTY DIRECTOR, OFFICE OF ASSET ENTERPRISE, DEPARTMENT OF VETERANS AFFAIRS; AND EVERETT ALVAREZ, JR., FORMER CHAIRMAN, CAPITAL ASSET REALIGNMENT FOR ENHANCED SERVICES COMMISSION

STATEMENT OF THE HONORABLE ANTHONY J. PRINCIPI

Secretary PRINCIPI. Thank you, Mr. Chairman, Mr. Rodriguez, and members of the committee. It is always a pleasure to come before you, and certainly on a subject of such great importance to our nation's veterans.

I want to publicly thank the chairman of the CARES Commission, Ev Alvarez, for his extraordinary efforts, his dedication, and

commitment to this process. He took a lot of time out of his life, out of his business to put together what I thought was a superb Commission report and recommendations. And I know of no man or woman who is more devoted or second to their just absolute commitment to doing what is right for our nation's veterans. And I am just very, very thankful to him as I am to everyone at the VA and the veteran service organizations who I believe contributed mightily to this effort because I can think of no more important effort than the one that we undertook and the one that we reported to you recently.

So I appreciate the opportunity to discuss VA's multi-billion plan to improve both access to and the quality of veterans medical care.

And in my written statement, this subcommittee's draft capital asset legislation, I am very strongly supportive of that legislation. There are a couple of issues that I am confident we can work through between our staff and committee staff to see if we can get a few refinements to some of the policy proposals. But by and large I think it will be enormously helpful to the agency in the modernization effort.

And I ask that my written statement be made part of the record.

Mr. SIMMONS. Without objection, so ordered.

Secretary PRINCIPI. If enacted, the draft legislation would go into effect in the context of the CARES plans road map to bring the veterans health care system into the 21st century because indeed in my opinion we have been stuck in the 20th century for too long and the time to get on with the modernization effort is now—not tomorrow, but today.

Over the past half-century, in both the practice of medicine in this nation and the veteran population, the demographics of the veteran population have changed rather dramatically. And they will continue to change in the future. And the veteran population regrettably is declining due to the passing of many of our World War II veterans, Korean veterans now up in that age group, 1,800 a day in this nation we are losing. As you can see on this first chart, the decline in the veteran population as projected over the next 20 years.

These changes are even more dramatic when evaluated on a regional basis as shown on the next two charts, which break out projected changes in veteran population and veteran enrollment for VA care on a state by state basis. On that chart to your left you see the dark, dark red in some of the northern tier states and even a decline in southern tier states as well. There are others the decline is relatively small but nonetheless with this passing of our elderly veteran population, which are way out in front of the general American population, we will have this change. And the enrollment, we also see declines in enrollment in certain states going from the dark red and we see increases that are highlighted in the dark blue. So the CARES decision, recommendations and decisions are designed in part to take into account these changes in the demographics of our veteran population.

So in summary there are dramatic reductions in population nationwide and a movement, as with the general population on a whole, the migration movement of the nation are moving from the Northeast to the South, to the Southwest and certainly to the

West. And I believe strongly, Mr. Chairman and members of the committee, that America will not keep pace with its commitment to veterans if we do not adapt to the changes in the population we serve and to the progress in the practice of medicine.

As you can see on the next two charts, we are into the 21st Century with a legacy infrastructure that is very, very old. On the left you can see that the vast majority of our infrastructure is now between 51 and 75 years old. We even have some that we inherited from the Army at the turn of the 19th Century, 1895, after the Civil War. Those facilities are still part of the VA.

But we also know that American medicine has transformed itself from hospital-centric to patient-centric. So whereas most of our facilities were designed and built in an era when medical care was synonymous with hospital care, it certainly made sense at that time to define our nation's health care commitment to most veterans as access to a hospital bed to the extent that beds were available.

And, of course in many cases, our facilities are located where veterans used to live, not where they live now. And today's veterans, as I know you agree, deserve better. And VA's medical system has made some changes over the past few decades. Prior to 1994 and 1995, we had virtually no outpatient clinics in the VA health care system. Today, we have over 800 outpatient clinics. And we have closed some facilities in past years, at Fort Howard in Baltimore, Fort Lang, CO, for example. We dramatically changed the missions of others, such as Grand Island, NE, Miles City, MT. But all of these changes were ad hoc and incremental.

And the CARES process was initiated by my predecessors and I carried it forward because it is important. It is important to the VA and to the veterans we serve as well as the Congress that answers to the American people. And because we must have a comprehensive national plan to modernize our medical facilities. In fact, as you can see from the next chart, the Congress has reduced funding for VA construction to a bear minimum until the VA came forward with a database national plan for updating VA facilities.

And CARES is that plan. The draft national CARES plan was developed by the Veterans Health Administration based upon data from VA's grassroots and input from VA stakeholders. I then established a 16-member independent commission, as I indicated, chaired by Ev Alvarez, a former VA deputy administrator and former Vietnam POW to evaluate that plan. And the Commission made their recommendations based upon numerous site visits, 81, 38 formal public hearings after considering more than 200,000 comments from veterans, employees, communities, and other interested parties.

And my acceptance of the Commission's recommendations was the first step, and only the first step, on a journey of modernization and new construction such as veterans have not seen in decades.

In summary, we will build new hospitals in Las Vegas—and seven is a lucky number—and Orlando, Florida. We will open 156 new outpatient clinics throughout the country, primarily in rural and highly rural areas that do not meet access standards so that veterans do not have to drive 4 and 6 hours to get the care they earned. They can get that care much closer to their homes. There

will be a major expansion of outpatient clinics in Columbus, OH. We will build new bed towers in Tampa, Florida and San Juan, Puerto Rico. We will open up two new blind rehabilitation centers and five new spinal cord injury centers.

And the CARES plan identifies more than 100 major construction projects in 37 states, Puerto Rico, and the District of Columbia. Yes, it does call for some consolidations and change of missions of facilities where we can bring greater effectiveness and efficiency to our operations. But we will only do so when we modernize that receiving facility.

I believe that veterans have waited too long for systematic nationwide modernization and improvement effort on our VA health care system. And CARES will transform our center, not today—I mean not immediately but over the next 20 years. But veterans will begin to see improvements much sooner than that as new funding, the plan identifies approximately $1 billion a year over the next 5 to 6 years for these new facilities.

The next chart, Chart 7—the next chart, please. Is that the one that shows the increase in funding?

So in conclusion, Mr. Chairman and members of the committee, I believe it is important that we move forward with this plan and continue to work with the Congress, with our staff, with our communities, with our stakeholders to ensure that the implementation is done and done well. I have established a CARES implementation board that report to me directly to ensure we meet our goal of improving access and quality care for the veterans we serve. When the process is complete, veterans will have improved access to a much more modern health care system.

I thank the Chair. I thank the Ranking Member and members of the committee for allowing me to testify this morning. Thank you.

[The prepared statement of Secretary Principi appears on p. 65.]

Mr. SIMMONS. Thank you, Mr. Secretary. Next, we look forward to hearing from the Honorable Everett Alvarez, former chairman of the CARES Commission. Mr. Alvarez.

STATEMENT OF EVERETT ALVAREZ, JR.

Mr. ALVAREZ. Mr. Chairman, thank you. Mr. Chairman, I have submitted a statement for the record, and if I may just summarize it in my oral statement.

I am pleased to be here today on behalf of the CARES Commission to discuss the CARES Commission Report, which was presented to Secretary Principi on February 12th of this year.

I can attest that the commissioners recognized the enormity and importance of their task to critique and modify a blueprint for enhancing the health care of as many veterans as feasible into the future. And let me emphasize, sir, that the Commission viewed the draft national CARES plan as a blueprint for VA health care for the next 20 years.

Health care delivery in this country is changing. The VA's health care delivery is under change and this change needs to be managed carefully and respectfully. The Commission sees this blueprint as a road map to the future, a tool to help managing future change.

The Commission, within time restraints, evaluated an enormous amount of data, listened to many veterans, providers of care, and stakeholders at 81 site visits and held 38 public hearings across the country and focused our collective experience and reasonableness on the task. Our report, which you have, is large and far-reaching. It included important discussions and recommendations on issues that cut across the entire VA health care system. It also included hundreds of site-specific recommendations. If the plan is to succeed in its goals, priorities still need to be attended to and properly aligned. Evaluations still need to be conducted for important components of VA health care and internal processes need to be overhauled.

I wish to share the key principles that served as a beacon to guide the Commission throughout our complex deliberations. First and foremost, to improve access to as many veterans as possible to high-quality veteran-specific health care. Many VA facilities were largely built 50 years ago or more, as you have heard. Population demographics have shifted. The delivery of health care has increasingly become an issue of access both for veterans and their families who need to partner in their care.

Cost-efficiency. When the health care needs of some veterans are unfulfilled, particularly for the highest priority veterans with war-related physical and mental disabilities, then efficiency is also an issue of access and quality of care. If we do not use resources as efficiently as we can, some veterans in dire need of services may not receive the care they need or deserve. Therefore, the Commission also looked at the cost benefit of the recommendations.

We recognize that the cost data provided were often in need of further refinement, forcing us to consider the likelihood based on our past experience in the Veterans Health Administration and a test of reasonableness that an action would improve efficiency.

The impact of change in the status quo on current recipients of service, current VA employees, and the communities where our facilities have been historically located was another key principle that guided the Commission. The Commission recognized a shifting of resources necessary to improve overall access would be a hardship for some. We expect that the implementation of necessary change will take this into account when the time lines for modifications are finalized. The Commission's recommendations were our assessment of what is best for VA health care as the VA moves forward. We are not infallible. We understand that things will change over time and there may be factors that need to be reconsidered. However, this was our best effort.

Mr. Chairman and members of the subcommittee, I would like to thank you for the opportunity to be here this morning. I would be pleased to respond to any questions you may have. Thank you.

[The prepared statement of Mr. Alvarez appears on p. 85.]

Mr. SIMMONS. Thank you very much. Do any of the other individuals at the table have a statement they wish to present? Hearing none, we will move on the question phase. Let me start with you, Mr. Secretary. In reviewing some of the press coverage of the CARES project and listening some of the discussion surrounding the CARES process, the issue has been raised that long-term care facilities and mental health services may or may not have been

fully incorporated into the planning process. Could you address that issue, please?

Secretary PRINCIPI. Yes, Mr. Chairman. I know that is an important issue. First, let me state from my perspective; long-term care, mental health programs, acute mental health, and long-term care for the mentally ill are critically important core programs for my agency. And soon we will complete and validate our utilization model for long-term care and for long-term mental health. The results of those models will be incorporated into our CARES plan. I chose not to wait with regard CARES because I believe it was too important.

But at the same time, I made a commitment that we not diminish our capacity to treat veterans in need of long-term care or inpatient mental health services. The location might change, but in many cases the location should change. Veterans with mental illness should not be consigned to facilities that were once asylums when we warehoused the mentally ill in rural areas away from their home. Those patients should be treated closer to their home, in modern facilities, and where feasible on an outpatient basis. But at the same time until the models are completed and incorporated, there will be no diminution in the level of care provided to those populations.

Mr. SIMMONS. Thank you. For Mr. Alvarez, there is no question in my mind about your distinguished service to the country in many different ways. And certainly taking on the task of being chairman of the CARES Commission was not an easy task and was something for which we are all very grateful and we thank you for that.

The question I would like to ask goes to the issue of bias or problems. Did the Commission encounter any problems in the course of its hearings or its travel around the country? Did they hear any criticism that might raise the issue that they were biased toward one region or another, towards one set of recommendations or another, did that occur?

Mr. ALVAREZ. Mr. Chairman, thank you. We conducted 38 public hearings but we had also 81 site visits and at each site visit we had lengthy discussions with stakeholders, employees, and members of the community. To be honest about it, I thought that the process was very open and in terms of any biases I don't think that any of our commissioners were in any way biased in terms of preset notions or concepts. I believe that we did an honest evaluation and assessment, listened as carefully as we could, took all of these into consideration and our recommendations that finally resulted were basically a consensus. We had 16 members in our Commission with a very extensive array of experience both within the VA system and outside, all experts in their field. And I thought that they all really, really tried not only to be objective but were committed to doing what was right.

And, as a result, I thought that the final product, our recommendations to the Secretary, reflected an honest evaluation of what was best in various areas that we covered here. The changing demographic needs were quite evident as we traveled around the country, and as we looked at the projections, the projections over

the next 20 years, it was very evident where the needs were going to be.

Mr. SIMMONS. I thank you for that response, because I think we have already heard that there are some facilities in the South and in the West. There are other facilities in the North and the East that might be closed. And I guess what you are telling me, and based on some of the materials you have presented, is that these recommendations are scientifically based, they are not politically based, is that correct?

Mr. ALVAREZ. Looking at the model and the projections, these recommendations are definitely not politically based. We also recommended that the model be fine-tuned and improved, at each iteration, which I understand that the VA is doing, which would justify the initial thoughts and findings that we had. But looking at those projections down the road, it was pretty hard to argue with what we saw. Like Secretary Principi said, seeing a tremendous decline in the World War II population which is a major part of the people that are being served out there, yes, sir.

Mr. SIMMONS. I thank you. My time has expired. Mr. Rodriguez?

Mr. RODRIGUEZ. Thank you, Mr. Chairman. Mr. Secretary, welcome once again. Let me say that on May 7 Deputy Secretary Gordon Mansfield traveled to Waco to announce that the Waco VA Medical Center would not be shut down but that further studies would be needed to determine its future. The VA committed to working with the community there in Waco and the stakeholders on a master plan for any action that would be taken on that master plan. However, on May 20, I was told that a construction request was sent to the committee that included $56 million for a psychiatric and blind rehabilitation clinic to replace Waco. In addition to that, Mr. Secretary, the committee received a request for a lease to move the Waco outpatient clinic off the Waco VA campus. I would think that if you are looking at a master plan, that you would at least wait a while. I want to get some feedback from you on that.

Secretary PRINCIPI. Certainly, certainly. That is an important issue. I made the decision to delay a final decision, if you will, on the Waco campus. I think it is a reflection of stakeholder congressional input into the process. I had a meeting with Mr. Edwards and others about the situation. I was unclear about the cost benefit of moving the psychiatric patients to the Temple campus. We do need a new long-term care facility in Temple. And part of the dollars in the budget reflect that. We do need to do a master plan at Waco. We have too much land, too much excess space.

No one is in disagreement in Waco. The community, the veterans, members of the delegation all feel that the Waco campus needs to be modified somehow because we just have hundreds of acres of land and many empty buildings on the campus. There is money in the budget, a placeholder if you will. We are going to do a further review of the cost benefit analysis and quality of care issue. Quality of course is very, very important before a final decision is made whether to move the psychiatric patients over to Temple.

Mr. RODRIGUEZ. So apparently you haven't made that decision yet?

Secretary PRINCIPI. No.

Mr. RODRIGUEZ. But on the decision to start that $56 million on construction, wouldn't it be wise to wait until the master plan is developed?

Secretary PRINCIPI. We have a long way to go. We have requested, we submitted it up here per the notification requirement but we are not going to do any construction at Temple until a final decision is made.

Mr. RODRIGUEZ. Thank you. Let me follow-up, Mr. Alvarez, I want to thank you for all your work. I know you got a big salary for doing that hard work and we thank you very much for all that. I know you are a veteran, an ex-POW and chairman of the CARES Commission and I know you took a lot of time and effort in putting this together. Let me ask you I think to follow-up on the chairman's question about possible biases. The recommendations that you made, are there any ones that you thought or you feel that maybe should have gone in that didn't go into the report?

Mr. ALVAREZ. No, sir, our recommendations were all based on the draft national CARES plan. So we looked at all of the items in the draft national plan and our assessment I felt was very objective. In doing so, we basically had an unanimous agreement on our position on each of the recommendations.

Mr. RODRIGUEZ. In retrospect, is there anything else that you feel maybe you should have done or could have done or maybe for future assessments?

Mr. ALVAREZ. Well, to be honest with you, no. We worked on it for 13 months. And in that time frame we saw that things were continually changing in terms of the planning process and what have you. For example, the model that was re-used was continually being refined and updated and that is fine. And that would become a part of the strategic plan for the VA, that is fine. We saw the needs out there. There were some needs that we thought were——

Mr. RODRIGUEZ. Mr. Chairman, I wanted a little bit more time. Were there any items that you recommended, I know you talked about the consensus within the committee, but where maybe the Secretary or the VA might have changed. Were there any recommendations that were made by the Secretary that were not part of the priorities that were made by the committee?

Mr. ALVAREZ. No, sir, none that I can point out. No, sir.

Mr. RODRIGUEZ. Okay, thank you very much.

Mr. SIMMONS. Mr. Beauprez?

Mr. BEAUPREZ. Thank you, Mr. Chairman. Mr. Secretary, being a bit parochial if I might, talking about the Fitzsimons project, surprise, if I understand correctly, we have already authorized for this project to move forward to a degree. It does involve, as I am aware, a very long-term land lease. The VA will own the structure of the tower that is proposed now but a very long-term land lease. I think a 75 year land lease. Do we need to do anything legislatively in Congress to make so that happens? I want to make sure we don't hit a speed bump here.

Secretary PRINCIPI. Yes, the draft bill has a proposal to authorize us to enter into 75 year leases. We do not currently have that authority. We are limited to 20 years I believe, right counsel? We are limited to 20 years and we could not go forward with constructing

a bed tower of this magnitude, of this cost, where we would be limited only to a 20 year lease. So it is critically important that the Congress give us the authority to get the 75 year lease period. And that seems to be non-controversial. And hopefully we will get it very soon.

Mr. BEAUPREZ. Let me stay on that point for either you, Mr. Secretary or Mr. Alvarez. It crosses my mind I used to be a banker and managing the facilities assets, the capital assets of a company is one thing. But to anticipate it would seem to me that the facility needs, the flexibility if you will, of long-term assets for a very dynamic population as you already pointed out with your graph, the population is changing, both in where they are located as well also in terms of numbers. And then to complicate it even further, the way we are rapidly transitioning in the way we deliver health care in this country, if you look back historically where you got sick, you went to the hospital, you stayed in the hospital and now we do much more outpatient.

And how do you, and I am guessing part of the answer is flexibility as we are just talking about more leasing options and perhaps more lease space. But how do you build adequate flexibility into your capital assets as you look forward to some how match those needs. So you are not so heavily invested in facility that very quickly becomes outdated?

Secretary PRINCIPI. Perhaps I can defer to some of the experts at the table here but clearly it is really based upon demand and projections over the next—the life cycle, if you will, of the facility that we are building. Historically, we built facilities that were much too large even up in the recent future where you will build a facility to 1,000 beds and today we might have an average daily census of 250 or 300. And obviously part of the reason for the CARES process is to do it the right way.

A lot of careful thought goes into the size of the facility, the trends in medicine, the demographics of the veteran population, the opportunity to share with the Department of Defense, which we will be doing at Fitzsimons. It will be a VA, federal health care component to this world-class campus that is being constructed at Fitzsimons. And it is important that we are part of it. It will bring high-quality health care to veterans in the Denver, CO area.

We are very excited about it. We are going to size it appropriately, share common services with the university to keep our costs down. The VA will govern its facility. The governance issues are taken care of. I think we have a very good model on how this should be done.

Mr. BEAUPREZ. If I might on my time remaining, on a more global perspective, still using Fitzsimons as maybe a reference point. The old 500 building that sits out there on this old Army base was a hospital originally, not being used as a hospital now. But thanks really to I think the foresight of the University of Colorado folks they are keeping that beautiful old historic building and it really is going to be a monument, a memory of the past. A room there where President Eisenhower recovered after a heart attack has been turned into a bit of a museum piece, if you will. I have had some of my colleagues approach me on the floor of the House concerned about historic preservation.

Has that entered into the process, the CARES process, does it have a place in our overall long-term capital asset plan? Are there buildings that even if they are not going to be part of the veterans health care unit that we ought to have a methodology of making sure that the great old buildings of the past are somehow protected and safe?

Secretary PRINCIPI. The answer is yes. Go ahead.

Mr. SULLIVAN. Yes, sir, we have an authority, enhanced use authority, that we have used successfully in several places where we are taking that authority which lets us lease out those historic buildings to non-profit organizations or historic organizations and find a continued use for them when VA doesn't have a use. And we recently are in the process of doing one in Leavenworth, KS and we also are looking at doing that right now in Milwaukee, WI. Again, it is a good tool for us to use to minimize the cost on veterans so we can spend that money towards medical care while still preserving those historic assets.

Mr. BEAUPREZ. Thank you for that, and I will just close by citing this chart. My compliments to all of you. This is the kind of story we ought to be taking not only to our veterans but to our taxpayers that we are finding more efficient ways to utilize the limited financial resources that are always available. You are going to be returning billions of dollars over a relatively short period of time.

Secretary PRINCIPI. Well, that is exactly right. To take that vacant space and to save $275 million a year that is used to treat more veterans and not to heed or maintain excess infrastructure but rather to be applied to the benefit of veterans and better and higher quality health care. And that is really what this is all about.

Mr. BEAUPREZ. Thank you, Mr. Chairman.

Mr. SIMMONS. Ms. Berkley?

Ms. BERKLEY. Okay, thank you, Mr. Chairman. First, I also wanted to lend my voice and thank Mr. Alvarez for his extraordinary effort on behalf of the veterans. I know it was not an easy task and I think he did it well and came up with an outstanding result and I thank you very much.

Secretary Principi, earlier this month I sent you a letter. I suspect you haven't even seen it yet but when I found out you were going to be here it was just perfect so I could ask you in person do you think you can give me—the content of my letter was to ask you for a status check and a time frame for the new VA medical complex in Vegas.

Can you give me some idea of expected time for site selection, land purchase or land transfer, building design? And let me also ask if you have heard from the DOD in response to your letter regarding the O'Callahan shared facility? I am kind of curious about that.

And for the record, I want to compliment you also on the way you have done the site selection. It has been totally non-political. I have absolutely no idea which pieces of land in southern Nevada are on the final list and that makes me very happy because every developer in Las Vegas has called me to tell me how they can develop this land. So I am glad it is on your shoulders and in your shop but I kind of would like a little indication of when we are going to make this grand announcement?

Secretary PRINCIPI. Great. Well, I understand the staff are ready to come up and brief me on their proposed site for Las Vegas. So we are at that point now of identifying the preferred location. And once that decision is made we can go out and procure the land or if it is the parcel that we can get from Bureau of Land Management, BLM, for free, which is always my choice if it is the right location, that should be within the next couple of weeks and we can let you know about that location.

This is a very high priority project. I have mentioned that to you, and I am committed to getting this medical center constructed in a short time frame. We have allocated $60 million for the design, am I correct? The design work which will begin, I understand will probably get underway as early as next month on selecting an architectural firm to begin the planning for it and late 2005/2006, if all goes well, we should be able to break ground on the new medical center. And then of course just the time of construction, I guess, a couple of years to get it done. But we are talking in very, very short time frame, Congresswoman Berkley.

Yes, we have been in communication with the Department of Defense, with the Department of the Air Force in particular. I have not seen their letter but we are working through our issues with them and I am confident that it will all be resolved.

Ms. BERKLEY. Okay. In conclusion, we built 5,000-room hotels in less 18 months in Vegas, so we can really help get this expedited.

If I don't have an opportunity to publicly thank you in the next few months, I want to tell you what a pleasure it has been not only working with you but getting to know you as a person. It is one of the true enjoyments I have had, and I thank you very much. And I hope that our friendship continues long after the two of us are no longer in our respective positions.

Secretary PRINCIPI. The feelings are mutual. Thank you very much, Congresswoman Berkley.

Mr. SIMMONS. The distinguished former chairman of this subcommittee, Mr. Moran.

OPENING STATEMENT OF HON. JERRY MORAN

Mr. MORAN. Thank you for not saying "the former distinguished chairman of this subcommittee."

[Laughter.]

Mr. MORAN. Mr. Chairman, thank you very much. Mr. Secretary, nice to see you today. I would echo in part about Ms. Berkley's comments just about the quality of service you are providing to the veterans of the country. Every time I talk to veterans the story is one of great faith in you, a recognition of your sincere interest in their welfare, and I just once again with you in the audience want to reiterate my strong belief that you are doing an admirable job and look forward to working with you.

In that regard, I also met the VISN director in Denver, and I am very pleased to make his acquaintance. I have spent most of my time working with the VISN directors in Kansas City but recently have discovered that a number of my counties, six, perhaps those in the other time zone, are in the other VISN. And so we are working on a CBOC issue and your VISN director in Denver has kindly agreed to come to Kansas and talk to my constituents. And so Mr.

Biro is certainly making a positive impression upon me, and I thank you for hiring and bringing about people who I deal with that are also very much committed to veterans.

My question, at least initially, is a couple of kind of broad questions and then one very specific about CBOCs. My understanding is that the CARES Commission made a recommendation that the VA criteria for determining where a CBOC should be located needed adjustment. And it is an issue that I have raised with the VA before. It seems to me there is over emphasis upon number of veterans and a lack of at least a moderating factor dealing with distance to access, distance to health care centers.

And so in Kansas it is easy for us to have communities that are long distances from a VA hospital but still may not meet the criteria of number of veterans. And my request, my suggestion is that there needs to be a balance. That a CBOC may be very much appropriate based upon number of veterans but when they are lacking in numbers, take into account the fact that those veterans are driving 4 or 5, 6 hours to a hospital. And I think there perhaps was a debate between Mr. Alvarez's CARES Committee and the VA about that criteria.

And then just more broadly, I am interested in knowing as you look to the future of meeting the needs of veterans, the prescription drug benefit plan that Congress passed last year that is now being implemented, I know one of the significant factors in driving veterans to the VA system has been the access to prescription drugs.

Are you all taking into account, is it far enough along to have any kind of indication that the prescription benefit may reduce the pressures upon—let me say that succinctly. The prescription drug benefit under Medicare may reduce the demand for health care services under the VA?

And then secondly, what are you seeing in regard to the current war on terror? Your charts and discussion involve the diminishing number of World War II veterans but are you seeing a corresponding increase in demand for VA services as a result of the current engagement our country and its servicemen and women are engaged in? And, if so, have you been able to determine any kind of specialized needs? Our subcommittee, including Mr. Simmons, has focused a lot of attention on how do we prevent these servicemen and women returning from the war on terror in Afghanistan or Iraq from encountering and suffering from the similar kinds of symptoms as they did in the Persian Gulf War. And is there in your planning process, are you looking at what kind of ailments these veterans may incur as a result of their current service to our country?

Thank you.

Secretary PRINCIPI. Thank you, thank you, Congressman. And I certainly echo your sentiments about the new network director in Denver, Larry Biro. He just did a phenomenal job here in the Northeast and I know he is going to do and is doing an equally job in his new network.

I am not sure if we will see much of a diminution in demand as a result of Medicare reform. We probably will see some at the lower socio-economic levels of our society where the co-pays under the Medicare reform legislation are very, very low, if any. The VA ben-

efit is a very attractive benefit at $7 per prescription, 30-day prescription per month. And Medicare reform does not match that. So I think the veterans will still gravitate to the VA.

And the other question——

Mr. MORAN. The war on terror and CBOCs.

Secretary PRINCIPI. The war on terror. We have seen roughly 20,000 veterans who have returned from Iraq, Afghanistan, including Guard and Reserve. Illnesses not necessarily related to their war-time experiences, just general ailments that they are coming to VA. So the numbers I think are relatively small. However, I think it is too early to tell what the demand will be in 3 to 5 years. And today we have not seen, and we are monitoring the battlefield, we are working closer than ever with the Department of Defense to understand environmental hazards of this battlefield.

What is of great concern, of course, I know to all of you and to us, is the nature of the injuries, battlefield medicine and body armor keeping young men and women alive today, but they are coming back with very, very serious amputations and head trauma. And at some point in time they will come to VA after they are discharged from the military or retire from the military because a lot of them can stay on active duty which is wonderful. But we need to focus on amputation research, rehabilitation, and the mental health component that comes with those kinds of serious injuries. And that is of concern to me to ensure that we are ready to treat them with cutting-edge medicine in the areas of their needs.

Mr. MORAN. Thank you, Mr. Secretary. My time has expired but I would be glad to follow up with you about CBOCs as well.

Mr. SIMMONS. Mr. Rodriguez?

Mr. RODRIGUEZ. Thank you very much. I want to try and be brief. I am going to ask you one question that I was asked by the nursing home people but before I do that, let me just share with you that one mission that I know you hold dearly is the fourth mission of the VA and that is in case of a natural disaster or man-made that we respond.

The VA is the only system nationwide with a health care network. We have passed some legislation in the past to try to establish four response teams in case of a national disaster, and I hope you keep that in mind because I know I have had a little difficulty with Homeland Security. Because of that legislation, the VA does have that responsibility and if we do need any help, the VA would be the one more able than Homeland Security to respond from a health care perspective. So I hope you keep that in mind as you look at construction and you look at the mission.

The question I was asked by the nursing home care people was, Mr. Secretary, that the facilities that are being envisioned to either being downsized or being converted, how will that affect the nursing home programs and will these changes allow the VA to restore the nursing capacity to the level required by law?

Secretary PRINCIPI. Well, we certainly are struggling with this issue to be in compliance with the Millennium bill on the number of VA nursing home beds. At the same time VA is trying to balance that with the needs of our patients who tell us they want to be treated at home. They want non-institutional care programs, respite care, adult daycare, hospital-based home care so we are trying

to move more aggressively and uniformly in that area. VA is also taking advantage of our community-based nursing home program that doesn't count toward that millennium bill floor or our state home program, which has been very, very successful, a great federal/state partnership.

So we are going to have our long-term care policy very soon and strive to be in compliance with the millennium bill.

Mr. RODRIGUEZ. Thank you, Mr. Secretary, and thank you for being there for our veterans. Thank you.

Mr. SIMMONS. The gentleman from Florida, Mr. Miller.

OPENING STATEMENT OF HON. JEFF MILLER

Mr. MILLER. Thank you, Mr. Chairman. Mr. Secretary, thank you for all your doing. We all appreciate the fine job that you are doing for our veterans and I associate myself with my remarks or the remarks of Mr. Rodriguez about the VA's ability to provide long-term health care needs for our veterans. I think by your own agency's numbers we are saying 1.3 million over the next decade, a tremendous amount of veterans that are going to be requiring that. And of course northwest Florida is no different.

But I did want to ask about the VISNs and how they are doing adhering to the CARES directives and if you could talk about what latitudes will those VISNs have in prioritizing construction projects within the VISNs?

Secretary PRINCIPI. Well, we try to give a maximum flexibility to our network directors consistent with policy that is developed in Washington, but with regard to the implementation of those policies, the locations of CBOCs within the networks, certainly try to leave it up to our network directors to make those decisions.

Mr. MILLER. I want to say that it appears Pensacola is well on track and on target and appreciate the assistance that you and your staff has been giving. Remind you again a much smaller project at Eglin that we would like to see dirt turned as quickly as possible. Those veterans are very happy that it is coming and they do need their CBOC as soon as possible.

Secretary PRINCIPI. Dr. Lynch is doing a phenomenal job, and I know he is committed to Eglin, as he is to Pensacola.

Mr. MILLER. That is all, Mr. Chairman.

Mr. SIMMONS. Mr. Bradley, from New Hampshire.

OPENING STATEMENT OF HON. JEB BRADLEY

Mr. BRADLEY. Good morning. Thank you very much, Mr. Chairman. Mr. Secretary, thank you. First of all, I just want to thank you again for I think three visits in the last several months to New Hampshire, being able to not only talk to the New Hampshire legislature, which is——

Mr. SIMMONS. You are not running for President, are you?

[Laughter.]

Secretary PRINCIPI. No, thank you.

Mr. BRADLEY. The New Hampshire legislature, for those of you who don't know, is the third-largest English-speaking legislature in the world, behind only the British parliament and our body. So we appreciate that.

And I do have one New Hampshire-specific question that I will ask you offline afterwards but I just wanted to let you know that Dr. Levinson of the VA in Manchester I think is doing a good job of complying with your directive to make sure that New Hampshire veterans are treated to the extent possible for outpatient type of maladies in New Hampshire or being served by Catholic Medical Center or the Elliott Hospital in Manchester, as opposed to having to travel to Boston. So we seemed to be making progress there.

I was here late. I don't know if anybody has addressed this question but my one question on a more general area is the Priority 8 situation and how you envision re-looking at your decision and where we may be going with that to be able to open the VA health care system back up to Priority 8 veterans?

Secretary PRINCIPI. Certainly. Well, just quickly on the first point you made, I think it is clear to me that we were sending too many patients, veterans from New Hampshire down to Boston for some routine primary care visits, and we simply need to do a better job of meeting their needs closer to home. It is just too far for a lot of elderly veterans to make that trip. And we are monitoring that very, very quickly.

We continue to focus on our disabled and our poor. And the demand for care from Categories Group 1 through 7 are basically still very significant, and I don't envision opening it up for Category 8 this year. But with the new budget in 2005, I am going to certainly take a look at it again and see if we are able to reopen enrollment to Category 8's. It is just a year to year decision but I feel strongly the disabled and the poor need to get the highest priority.

Mr. BRADLEY. Thank you, that is all I have, Mr. Chairman. But I will ask you the specific New Hampshire question afterwards.

Mr. SIMMONS. Mr. Ryan, do you have any questions?

OPENING STATEMENT OF HON. TIM RYAN

Mr. RYAN. Thank you, Mr. Chairman. I apologize, Mr. Secretary, for being late. As you know, schedules are crazy. First, I want to thank you for all your efforts. I know you are working extremely hard under extremely difficult budget conditions. I represent northeast Ohio, Youngstown and Akron. And, as you know, we are beginning to talk about, and actually the decision has been made already, to close the Brecksville facility in Cleveland and consolidate into Wade Park. And I think it is by 2009.

So the question I get back at home, a lot of these veterans travel an hour or so to get up there, and the question that I get more often than not is will you be able and will the VA be able to keep the same level of services, continuity of care, and everything that they have come to expect from the VA. Can you assure me that the level of service and services that these veterans get will not go down?

Secretary PRINCIPI. I certainly commit that to you, Mr. Ryan. I think it is a fundamental point. It is the premise upon which this entire plan is based that we will improve the quality of care. Before any closure takes place, there will be a major investment made in the Wade Park facility. I don't know the entire amount but it is an extremely high investment that we are going to be making in Ohio

for veterans. We have recently expanded the Youngstown, OH clinic, which is in great demand.

So it is my hope that by the consolidation, by the investment in construction dollars, by the expansion of our outpatient clinics, a new 300,000 square foot multi-specialty outpatient clinic in Columbus, we are going to expand the reach of health care in the state, and that is the foundation upon which this is built.

Mr. RYAN. I appreciate that and I appreciate your confidence. Also, I was at an event for the dedication of a clinic in Ravenna, OH, which is in Portage County, just about a hour south of Cleveland, and it is a phenomenal facility. It is really something that I think could be showcased around the country. And the administrators there and the doctors there were just so thrilled and a lot of the veterans were there. So I know a lot of times we talk about how we can make things better. You couldn't make that clinic any better.

Secretary PRINCIPI. Well, that is great to hear.

Mr. RYAN. From the decor, in fact I told the administrator who is running it, I said, "Keep my wife out of here, because this is so nice she is going to get ideas for our house." It actually is that nice. So I just wanted to let you know.

My staff and I have talked a little bit about what you have done in the Lakeside Hospital in Chicago. Did you learn anything in that process that you would improve upon as you do the consolidation with Brecksville and Wade Park and areas like Cleveland? Just things we should maybe be looking out for?

Secretary PRINCIPI. I think we have learned several lessons. That was the pilot test for CARES, if you will. And I am not sure we had as much stakeholder input as we did in this process, having a Commission, having more hearings in the community. I believe the decision was the right decision. I was just in Chicago for the naming of the new Jesse Brown VA Medical Center in West Side. I saw an artist rendering of the new Bed Tower that is going to be built with the dollars that we are going to be getting from the Lakeside facility to bring really state-of-the-art health care to Chicago.

So perhaps from the construction basis and how we go about valuing the land, what the land is worth, we have had some issues there. But I think we have learned a good deal and we have applied those lessons to this second phase of our CARES process.

Mr. RYAN. One final question, I know my time is running short here. Are you confident with the amount of funding that you are getting to be able to do all of this construction and maintain the continuity of care and the services, are you confident that the funding will be there to accomplish the goals?

Secretary PRINCIPI. Well, I think it is critically important, Mr. Ryan. I really do. I am pleased that the President, the Congress, the Members on both sides of the aisle have been so supportive of the VA and veterans. We have almost a billion dollars in the bank so to speak for this first round of design work in 2004 and 2005. I am going to do everything in my power to obtain the billion dollars a year that I believe the agency needs to modernize the VA health care system just in construction now. And I think it is criti-

cally important. I think the future of the VA depends upon us getting those dollars.

So certainly at my end of Pennsylvania, I am going to work very hard to do that. And I know the members of this committee in particular will be very supportive, so I am relatively confident, and I think with the veterans organizations' support we will be able to get there.

Mr. RYAN. I appreciate that and let me just pledge to you that I certainly want to work with you and your team to make sure that we do that. And I think there is going to be some difficult decisions that we are going to have make, even opportunities this week to realign our budget priorities to make sure that we do have the money that you need. And I hope that this committee and the members of this committee and this Congress will take that opportunity to assure our veterans that they have the quality of care that they need. So thank you very much for all that you guys do.

Secretary PRINCIPI. Thank you. Look forward to working with you, Mr. Ryan.

Mr. RYAN. Thank you.

Mr. SIMMONS. For our second round of questions, Mr. Beauprez?

Mr. BEAUPREZ. Thank you, Mr. Chairman.

Mr. SIMMONS. Will the chairman suspend for a moment? You appear not to be on the recording system?

Mr. BEAUPREZ. There. It was Beauprez Unplugged there for just a minute. See if I could sell that one.

I compliment you, Mr. Secretary. Your knowledge and awareness of your facilities across the country absolutely astound me. You obviously do your homework and are very committed to our veterans. Follow-up question in a little bit of the direction I think Mr. Ryan was going. One of the questions I get frequently, especially out West when I run into veterans is a concern about rural health care and the drive time distance. I think you mentioned in the CARES report, your plan, you will open 156 outpatient clinics. My question is what does that accomplish and are there still holes remaining somewhere in the big map that we have got additional concern about?

Secretary PRINCIPI. Well, the CARES plan calls for 156 clinics over the next 7 to 10 years or so. We have identified about 50 this first year and there will be others. Network directors are free to come in with a business plan to open up a new clinic. Our goal in primary care is to have 70 percent of the veterans within 30 minutes of an outpatient clinic in rural areas. In highly rural areas, it is 60 minutes. And then of course for in-patient care it is 65 percent of the veterans within an hour in rural hours. In highly rural areas, it is an hour and a half. So what we are trying to do is achieve a level, a standard of access that is around 70 percent live within 30 minutes of an outpatient clinic in rural areas.

Mr. BEAUPREZ. Any holes remaining? Do we have some parts of the country that will still be wanting?

Secretary PRINCIPI. There are always some holes and we are just trying to close them all. And gradually we are getting to that point where we are accessible to the vast majority of the patient population. We do have a chart to show you that when CARES is completed, we will improve access in primary care by 7 percent, acute

in-patient by 10 percent, and then of course tertiary care by 2 percent. So we are trying to close all the holes. There will still be some gaps and I leave it up to the network directors to identify those gaps and to propose a plan to close them.

Mr. BEAUPREZ. Thank you, Mr. Secretary. Thank you, Mr. Chairman.

Mr. SIMMONS. Thank you. I want to thank all of our witnesses at panel one. We have perhaps gone a little longer than we should have but this is a hugely important initiative for the Veterans Administration and for all our veterans. I did refer to the distinguished former chairman of the subcommittee who in fact occupied the chair when this process kicked off a couple of years ago, several years ago and it is an extraordinary process for the Congress, for the Veterans Administration, for all our veterans, and I, for one, look forward to working with my colleagues to make sure that the fruits of your labor are implemented on behalf of all of our veterans, and I want to thank you very much.

I also want to note for the record that I was looking at one of the Secretary's charts and this is major and minor construction from approximately 1983 to fiscal year 2005. There are two peaks of construction on this chart. One peak of course is at the period when Secretary Principi is heading up the Veterans Administration. The other peak is when he was staff director of the Senate Veterans' Affairs Committee. Is there any correlation between these two peaks, Mr. Secretary? You don't need to answer that question, I just point that out for the record.

The second panel today includes Mr. Dennis Brimhall, president and chief executive officer, University of Colorado Hospital; Mr. Lawrence A. Biro, Veterans Integrated Services Network 19: Rocky Mountain Network. They are here to update the subcommittee on legislation we approved last year to authorize VA to move forward on its need to build facilities at the new Fitzsimons.

Also we will hear from Mr. John L. Nau, III, chairman, Advisory Council on Historic Preservation; and Mr. Dennis Samic, treasurer, American Veterans Heritage Center. The need to protect and effectively re-use historic properties for which the VA is the legal steward, is important even as VA builds for the future. It is important for the Veterans Administration to meet preservation requirements in program and construction activities. And I look forward to the testimony of this panel. Speaking for myself and the State of Connecticut, we have some very old veterans facilities that have tremendous historic value. And while we wish to move our health care and our benefits programs well into the 21st Century, we also want to make sure that we preserve and protect our historic properties for future generations to learn from and to enjoy.

I would now like to yield to my friend, Mr. Beauprez, to see if he has any particular comments that he would like to make by way of introduction of those members of the panel who are from his lovely state.

Mr. BEAUPREZ. Thank you very much, Mr. Chairman, for your gracious consideration.

President Brimhall, as you have already acknowledged is president and chief executive officer of the University of Colorado Hospital. I am going to not spend so much time on his distinguished

resume, which is distinguished, but to talk about Dennis Brimhall's commitment to this project. This wonderful campus, the former Fitzsimons Army Hospital that we are going to hear about today, as the University of Colorado, through his guidance, redeveloped it, they certainly had numerous options. Working with the Veterans Administration was I would submit probably not the easiest of options. To deal with the VA and the Federal Government has to be bit of a burden.

But I would like to publicly commend President Brimhall for his tenacity, not only in trying to as I guess we would say out there in the business world put a deal together, but to put together a very wise, sound deal that is really going to be a legacy certainly to the University of Colorado's hospital network. It is a great teaching hospital. Has a tremendous legacy in its own right. But to work with the VA to maintain a very longstanding partnership that you have had with the Veterans Administration and the University of Colorado Hospital for more than 50 years now and now to bring in a third partner, the Department of Defense. This would not happen, and we sometimes say these sorts of things casually but in this case it is 100 percent true, it would not have happened if it weren't for the tenacity and dedication of President Brimhall. So it is wonderful to see you here today, Dennis. Look forward to your testimony.

And I would be remiss if I didn't also acknowledge the gentleman to your right, Mr. Biro, our new network director for VISN–19. Both of these gentleman have been embraced wholeheartedly by our VSOs in Colorado. They have immersed themselves in this project with the kind of professional dedication and personal involvement that we would love to see in project after project all over this great land.

So gentlemen, it is wonderful to have you both here.

Mr. SIMMONS. Thank you very much. We are in fact glad to have all four of you. I realize two of the four got some special and extra treatment but that is only because of their geographic affiliation with one of our members. So I thank you all for being here.

Mr. Brimhall, why don't you begin with your testimony.

STATEMENTS OF DENNIS C. BRIMHALL, PRESIDENT AND CHIEF EXECUTIVE OFFICER, UNIVERSITY OF COLORADO HOSPITAL; LAWRENCE A. BIRO, NETWORK DIRECTOR, VISN 19: ROCKY MOUNTAIN NETWORK; JOHN L. NAU, III, CHAIRMAN, ADVISORY COUNCIL ON HISTORIC PRESERVATION; AND DENNIS SAMIC, TREASURER, AMERICAN VETERANS HERITAGE CENTER, INC.

STATEMENT OF DENNIS C. BRIMHALL

Mr. BRIMHALL. Thank you very much. Mr. Chairman and members of the committee and especially including my good friend, Congressman Beauprez, greetings. Thank you for this opportunity to report to the committee on the status of this really remarkable project. After 80 years of serving the members of our Armed Services and their families remarkably, the Fitzsimons Army and Medical Center is now home to a 21st Century academic medical center, one that has been built from the ground up. And doing that

in such a way that it solves many of the infrastructure problems we have in health care referenced by Secretary Principi.

It is also home to a new and exciting partnership that will bring together one site, the University of Colorado, the University of Colorado Hospital, the Department of Veterans Affairs, and the Department of Defense.

Currently at the Fitzsimons Campus there has been completed or is under design construction four million gross square feet of new construction. This includes research, educational facilities, and patient care facilities, including a new University of Colorado Hospital and another partner we have, the Denver Children's Hospital. There will also be at this site, this remarkable federal tower. This federal tower will include a new Denver Veterans' Affairs Medical Center and a new military treatment facility, which would have been built at the Buckley Air Force Base, but now will be part as part of this federal tower at the Fitzsimons Campus.

The advantages of this partnership are truly significant. First, as it relates to quality. We will be able to take the very best of all of these partners and bring them together. Another important quality issue that we all know is in medicine the more you do, the better you get. And as we bring all of these partners together and their respective constituents, we are able to increase the numbers of procedures and the numbers of activities there and therefore improve the quality based upon the fact that we aggregate these in one place.

The other great advantage is cost savings. By not having to duplicate facilities or equipment that might be located in each one of these three facilities we can bring them together and that saves us significant savings on the capital side. But probably more significantly over the long run is the savings on the operational side. The more we put through a fixed asset, the savings are significant. And they accrue to all partners equally. That is the exciting thing is everybody in this relationship benefits and that benefit continues over many years.

I think the other exciting benefit of this is it is a new model, really an opportunity to re-think, to re-invent, to do things differently than they have ever been done before. We believe, we have been told, we hope that this will be a model for the future for many different areas of the country who will then accrue the same benefits to them that we have received in Colorado.

In conclusion, may I just say that it has been a delight to work with the Department of Veterans Affairs. The senior leadership of the Department over the last 3 years as I have been involved in this have been open and innovative, been collegial. And even though, Congressman Beauprez, it was a daunting task to deal with a very, very large arm of our Federal Government, I must say it has been a delight and the leadership has been terrific.

Likewise, in the Department of Defense the leadership there the leadership there has been open and innovative to doing new things and doing them in a different way and that relationship has been terrific as well.

Thank you very much.

[The prepared statement of Mr. Brimhall appears on p. 88.]

Mr. SIMMONS. We thank you for your testimony, and now Mr. Biro, who is the network director of VISN 19, the Rocky Mountain Network. Welcome.

STATEMENT OF LAWRENCE A. BIRO

Mr. BIRO. Mr. Chairman and members of the subcommittee, thank you for this opportunity to appear before you to present my views on the potential sharing agreement with the Department of Defense on the Fitzsimons Campus.

As already said several times, I am Dr. Larry Biro, director of the VA Rocky Mountain health network, Veterans Integrated Service Network 19. VISN 19 serves an area covering the States of Utah, Montana, Wyoming, Colorado, portions of Idaho, Kansas, Nevada, Nebraska, and North Dakota. This network provides health care for approximately 140,000 veterans at six medical centers in 32 community-based outpatient clinics.

In his May 2004 CARES Decision Document, Secretary Principi made the following decision concerning the building of a new health care facility in Denver. I quote from the decision document. "VA will build a replacement VA Medical Center through a sharing agreement with the Department of Defense on the Fitzsimons Campus with some shared facilities with the University of Colorado."

The federal facility at Fitzsimons is a joint venture concept based in part on the VA/Air Force work in Las Vegas, Nevada and Albuquerque, New Mexico. As planned, this facility will be a federal tower housing the medical services of the Denver Medical Center and the medical services of the Buckley Air Force Base. The Air Force will occupy approximately 7 percent of the building for clinical and administrative purposes.

The new facility will expand the capability of the Denver VA Medical Center by significantly increasing the amount of space available for clinical services. Among the services being considered, a new spinal cord injury center will be a part of the new facility and other expanded clinical services, such as a 20-bed sub-acute care unit. In addition, a new 60-bed VA nursing home care unit will be located on the Fitzsimons Campus.

This re-location is also intended to maximize the efficiencies with the federal tower by working closely to share some facilities with the University of Colorado Hospital. To obtain these efficiencies, the new federal tower must be located as near as possible to existing and planned facilities of the University of Colorado Hospital. To that end, that University of Colorado Hospital has reserved a plot of land in close proximity of the existing and planned structures of the medical center.

The move to the Fitzsimons campus makes complete sense. The University of Colorado Health Science Center and the University of Colorado Hospital are totally committed to this site. The outpatient complex is now complete and in operation. There is an extensive research space that is near completion. The close proximity in conjunction with the well-established and longstanding affiliation will allow the use of the University expertise for hyper-acute and highly specialized care.

Acquisition of this property could occur through a long-term lease with the University of Colorado. VA's general counsel has advised us that VA currently lacks the authority to enter into a long-term lease that would give the Department sufficient interest in the land to allow VA to build a facility here, which we estimate may cost as much as $328 million. For a project of this magnitude, I believe that the authority for a lease of much greater duration would be needed to ensure the government has sufficient interest in the land.

If we cannot obtain the long-term lease, we will be forced to look for land that the government can purchase outright on or close to Fitzsimons. Although the new facility will continue to be a joint federal health care tower between VA and the Department of Defense, our opportunities to gain greater efficiencies through sharing arrangements with the University of Colorado might be more limited. Therefore we are grateful to the committee for introducing legislation that contains a provision that would assist us in re-locating to the Fitzsimons campus of the University of Colorado.

Mr. Chairman, that concludes my statement. I would be happy to answer any questions you and the members of the subcommittee might have. I have submitted a written statement for the record.

[The prepared statement of Mr. Biro appears on p. 99.]

Mr. SIMMONS. Thank you very much, Doctor. Now we will hear from Mr. John Nau, chairman of the Advisory Council on Historic Preservation. Welcome.

STATEMENT OF JOHN L. NAU, III

Mr. NAU. Thank you. Thank you, Mr. Chairman and members of the subcommittee.

Mr. SIMMONS. If you would push your microphone.

Mr. NAU. Thank you for inviting me to testify. I am John Nau, chairman of the Advisory Council on Historic Preservation. The ACHP is an independent agency created by the National Historic Preservation Act of 1966. Our job is to advise the President and Congress on historic preservation matters. We also administer the Section 106 Review, the portion of the NHPA that deals with review of federal agency programs and projects that have the potential to affect historic properties. In this capacity, the ACHP has long been aware of the rich inventory of historic assets managed by the VA. In fact, approximately 40 percent of the VA's medical centers are identified as historic districts and contain over 1,900 historic structures.

In 2003, the White House launched a major historic preservation initiative entitled, "Preserve America." The initiative is designed to promote the appreciation and importantly the use of our nation's heritage assets in a manner that ensures both their long-term preservation and their continued contribution to the economic vitality of the country.

Of particular relevance to the VA's management of historic properties is Executive Order 13287, Preserve America, signed by the President on March 3, 2003. The overall thrust of the Executive Order is to encourage federal agencies to manage their historic properties in a way that advances the economic health of the community in which they are located and also promotes the preserva-

tion over the years. Central to this goal is the development of partnerships with state and local governments, as well as the private sector for economic development.

The historic resources in the ownership of the VA are some of the country's finest heritage assets. We have recently become aware of H.R. 1762, introduced by Congressman Michael Turner. This bill proposes the creation of the Veterans National Heritage Preservation Act. The ACHP strongly supports H.R. 1762 and believes it be an excellent compliment to the efforts discussed here today. Through the effective VA CARES program and the creation of the Veterans National Heritage Preservation Act, we can provide the thoughtful stewardship of the VA's premier heritage assets.

We support the VA's initiative in creating the CARES program but are concerned that it does not address how it would impact the historic properties under their management. As the Administration has so strongly emphasized in the issuance of the Executive Order, appropriate stewardship of these irreplaceable resources is a government-wide priority. There are five major issues related to the draft bill that I would like to bring to the committee's attention.

First, over the next 20 years it is anticipated that approximately $4.7 billion in capital assets will be needed to implement this program. This estimate includes $59 million earmarked specifically for demolition costs. We are concerned that if the VA is predisposed to demolition of facilities and funding for such activities is readily available, the VA will not be receptive to proposals for historic properties that involve leasing and/or adaptive re-use.

Second, we understand that the VA intends to unilaterally transfer real property under the CARES program. We recommend that the VA draw the experience of other federal agencies that have dealt with excess historic properties, such as the Department's of Defense and General Services. The transfer of real property, particularly historic properties, can prove to be very challenging, especially when the unique aspects of that historic property are not properly considered when negotiating covenants.

Third, we applaud the House bill's authorization for VA to use the proceeds from the transfer of real property for maintenance and repair, but we are concerned the bill places the use of such proceeds at the end of the line.

Fourth, the draft bill is silent on the obligation of VA to comply for transfers with the requirements of the Section 106. The proposed legislation provides an opportunity to encourage VA to engage in the Section 106 process early in their planning to ensure a balanced decision process.

Fifth, the VA needs to be aware that planning and site selection for new facilities may have an effect on historic properties. Since so many of VA's existing facilities include historic districts, we strongly urge that they consider this impact.

In closing, a properly crafted process can encourage transfer of historic properties where the new owner is committed to a long-term preservation strategy. Minimize neglect while properties await disposition, promote partnerships for creative use or cooperative management arrangements, and effectively involve the local community in re-use strategies that promote economic development.

Again, thank you for the opportunity today for me to share the views of the Advisory Council on Historic Preservation with the committee.

Thank you.

[The prepared statement of Mr. Nau appears on p. 102.]

Mr. SIMMONS. Thank you for that testimony.

Now we will hear from Mr. Dennis Samic, treasurer, American Veterans Heritage Center, Inc. Welcome.

STATEMENT OF DENNIS SAMIC

Mr. SAMIC. Thank you, Mr. Chairman and members of the committee. My name is Dennis Samic. I appreciate the opportunity to appear before you today to also talk about historic preservation. I am a retired Air Force Brigadier General who served nearly 30 years on active duty. And my son was born in Building 500 at Fitzsimons, so I was glad to hear all that this morning.

I am here today, however, as a member of the board of trustees for the American Veterans Heritage Center. It is a four year old Dayton, OH-based nonprofit organization. The mission of our organization is to increase awareness of veterans' issues, recognize veterans' contributions, endorse patriotism, promote tourism, and enhance our neighborhood by preserving and developing the Dayton, Ohio Veterans' Affairs Historic District.

Individual veterans and veterans service organizations hold many different opinions relevant to preserving old buildings but there are three things all veterans agree on. They want their service and sacrifice to this nation to be appreciated. They want it to be remembered. And they want it to serve as a legacy for those who come after. Our organization believes one of the best ways to honor our vets and preserve their legacy is to rehabilitate and utilize many of the historic facilities on VA property. This is a national issue.

We believe the approach our community took and continues to pursue could serve as a possible guideline for federal and national policy. We also hope our approach can be instructive for other communities as they develop their public and private partnerships. It is especially fitting that Dayton addressed the need for historic preservation because the Dayton VA campus is quite frankly the foundation for VA's modern health care. When President Lincoln established a national home for disabled volunteer soldiers on March 3, 1865, there were three original facilities: Dayton, OH; Milwaukee, WI; and Togus, ME. Theirs was a ground-breaking approach to veterans care which for the first time brought the Federal Government into responsibility for care of the needy.

The VA has taken initial steps to safeguard this heritage by either listing each of the now 11 national home properties on the register of historic places or determining their eligibility for listing. However, it is clear that the full significance of the national home within the context of this nation's history has not been assessed. We need definitive action to stimulate national preservation and to establish momentum.

Our organization supports the draft bill before us today because it has preservation in it. But we have basic concerns about how that bill will be implemented and how the capital asset fund it es-

tablishes will be utilized. To ensure this important part of our nation's heritage is preserved and protected, we urge your committee to include in your bill an incentive, if not a requirement, for the Department of Veterans Affairs to more actively partner with the National Park Service to prepare an assessment of 11 national home properties to determine which of the historic facilities are the most historic.

The goal is to keep these most historic buildings from being torn down before preservation can start. We, too, urge that as you mark your bill you try to incorporate as much as you can of the provisions of Congressman Turner's H.R. 1762. We think it is a great piece of legislation.

Once the assessments I mentioned earlier are complete, we urge your committee to require the VA to fund the creation of master utilization plans for these VA campuses. Dayton VA campus could serve as a pilot.

We applaud the establishment of the VA capital asset fund, but believe the priorities that you have established will make it difficult, if not impossible, for any of this money to find its way to historic preservation. Asset transfer costs have priority and they will be large. We urge you to establish a guaranteed percentage, perhaps 25 percent as a floor for historic preservation.

The draft bill gives authority to transfer property below fair market value for the purpose of benefitting homeless veterans. We urge you to also include historic preservation as a purpose for such a transfer. We can make it conditional that any building transferred must maintain its historic significance as a condition for anybody receiving that property.

And, finally, the bill describes a process for transferring real property. We urge you to include in one of the notification steps a statement certifying that the transfer will have no impact on a building on the register of historic places. And if it does, the Department should state that it has found no adaptive re-use for that building.

We understand Secretary Principi is about to sign a request to the Director of the National Park Service to begin the assessment I mentioned earlier. If it is completed, the VA can initiate development of master utilization plans for each facility. Creative local partnerships between the local VA, VSOs, state and city officials, nonprofit organizations like ours, the National Park Service, and private individuals and foundations can then be established to implement these plans.

We have such a partnership in Dayton. Secretary Principi was kind enough to cut the ribbon to our AVHC office in April of last year and we are making great progress. We have been added to the national historic register and look forward to historic landmark status. We are, as we speak, rehabilitating the first permanent chapel built in the United States by the Federal Government. And in the long-term want to turn the Dayton VA's historic chapel, patient library, administrative building and barracks into a National Veterans Hall of Fame.

We appreciate your holding these hearings to gain stakeholder input. We don't believe the VA will receive a large enough appropriation to provide for all the costs of both health care and preser-

vation. We do believe, however, that with your help and direction the VA will devote enough of the money it has to stabilize the historic facilities and formalization plans for its campuses. If the VA then encourages creative local partnership, which use these plans to build business cases to stimulate contributions, together we can satisfy the needs of both outstanding health care and preservation of these national treasures.

Some people believe the expenses associated with these recommendations are a cost. Frankly, we view them as an investment. It will reduce the fiscal burden that VA faces today to maintain buildings that they no longer need for patient care while at the same time allowing our nation to provide those three things all veterans want and deserve: thanks, remembrance, and legacy.

Thank you very much for this chance to speak.

[The prepared statement of Mr. Samic appears on p. 107.]

Mr. SIMMONS. Thank you very much. I would like to comment on the last two testimonies. I believe firmly that a partnership between multiple public and private entities is the way to go and that community involvement is a critical part of that. There is a tendency here in this body, in the Congress, to put dollars forward or re-allocate dollars for things that are supported locally and things that are supported by organizations such as yours, in partnership, and that is critically important, and I look forward to seeing how we can progress in that regard.

Speaking of partnership, I would like to address my first question to Mr. Biro and Mr. Brimhall. One of our members has been concerned in months past that the relationship between a Defense Department hospital and the VA in her area has not been productive. Speaking for myself, coming from eastern Connecticut where we have both the Coast Guard Academy and the submarine base at Greton and New London, we find that they are very productive relationships. But it is a challenge and you have to work at it and things can go wrong.

I would be interested to know from Mr. Biro how he feels he is getting along with Mr. Brimhall. And I would be interested to know from Mr. Brimhall how he feels he is getting along with Mr. Biro. And we are among friends. There happens to be a camera here but we won't pay any attention to that. How is it going? And if I was to ask let's say for a joint report to be presented to this subcommittee let's say in December, would we enjoy reading that report?

Mr. BIRO. Okay, first I have to say that the process of planning for Fitzsimons has been going on for several years. I have been in my position a little bit more than 8 months. So I am coming in at the end of it or in the middle of it, I guess not the end. And we have a very good working relationship. We have already worked together on a basic plan of services there. We have had several meetings. We have been limited because we haven't had money to use for planning and we are just beginning to plan and so we are going to continue to look. In about 90 days we will have a footprint that we can put into the site and see how it is going to work. So we are working together excellent and moving the project towards its natural conclusion.

Mr. BRIMHALL. Mr. Chairman, thank you. The relationship between the Denver Veterans' Affairs Medical Center and the University of Colorado Health Science Center actually has been going for 50 years. When the Department of Veterans Administration looked for a place to build its veterans hospital in Colorado after the Second World War, they deliberately sited it right next to the University of Colorado Health Science Center. So we have got a long tradition of that relationship.

We are now doing some new things that have never been before and that is we are moving out to a new campus. We have invited the VAMC to move to the new campus. I will say given the magnitude of this project and the innovation of this project, I would have to characterize the relationship has being very, very good. We have gotten where we have gotten today because of the positive nature of that relationship.

I will also say that it was the Department of Defense's interest to join us at the site. They had the option of either building a new MTF at the Buckley Air Force Base, which they decided was not wise given that investment and the fact that it would be isolated out on the base and it was their interest to join at the base and they came as a willing partner, and in some ways a catalyst to help us move forward. So I think the proof is in the pudding. The fact is we have gotten to where we are today because of the relationship that has existed and because of a mutual desire to be there. And I think the best example of how well we are working together is the fact that we have gotten to where we are today. And we would look forward to the opportunity to report back in 6 months about our progress.

Mr. SIMMONS. Well, I really welcome that response. And carrying it just a little bit further, it is my understanding that you hope to achieve efficiencies by sharing specialized care laboratory, dietetic, administrative services. To do so, do you engage in a memorandum of understanding? Do you have labor issues that have to be resolved from organization to organization? How does that structure get built and what are your challenges there?

Mr. BIRO. Well, from the VHA side, we do that with sharing agreements, contracts basically that we would have to purchase the services from the other side. There is going to be labor issues, correct. There may be positive ones where we will be adding people but there will be maybe negative ones where we will be eliminating people and the services will be done at the university hospital. So it is a process, it is an acquisition process. That is as simple as I can put it.

Mr. BRIMHALL. Mr. Chairman, again this is building on a tradition. The tradition is for example we have been doing transplant services for the VA for years. We have been sharing radiation oncology services. I think we are going to take an existing model and expand it. We have felt that the best thing to do is to do that when both parties benefit. If both parties don't benefit, there is no reason for us both to do it.

So I think it is an analysis that we will have to undergo that said can we do better collectively than we would do individually? And I suspect and I am confident as we do that analysis we will

find many opportunities to save and still maintain the respective missions.

So all of the challenges of contracts and arrangements and the issues that you have referenced we are comfortable we can work out because traditionally we worked them out and got us to the point we are now. We just have to expand that to a broader range of relationships but we have a good model that we think we can build upon.

Mr. SIMMONS. Thank you very much. I really appreciate that testimony. And I think what you have provided us for here is really a model for other parts of the country where we can achieve efficiencies and really create something that is extraordinary for the region, for our veterans by working productively together. And I thank you for that.

I would now ask my colleague, Mr. Beauprez, if he could assume the chair. I excuse myself, gentlemen, and ask my friend, Mr. Ryan, if he has questions for the record.

Mr. RYAN. I thank the chairman. Mr. Beauprez better get over here quick before I jump in it.

Mr. Brimhall, I read through your testimony a little bit that talked about the research and development that you guys do. Can you just, what are the top three or four things that you are doing research on at your hospital with regards to veterans?

Mr. BRIMHALL. Mr. Ryan, thank you. The University of Colorado is one of the top 20 universities that are recipients of NIH funding, National Institutes of Health funding in the country. Much of the research we do focuses in two or three areas. One is cancer. Another is pulmonary disease. As you know, the Fitzsimons Army Medical Base was constructed originally after the First World War as a place for patients with lung disease to go and recover. And so we have always had leadership in the area of pulmonary disease but also cardiac research and many others.

There is a large research component to the Veterans' Affairs Medical Center that is collaborative with the University of Colorado and we expect that collaboration to be enhanced by literally putting the research in common buildings and increasing that multi-disciplinary approach to the research.

Mr. RYAN. You don't do anything with prosthetics at all?

Mr. BRIMHALL. We do have a department of rehabilitative medicine. It is a full department. It is ranked as one of the top rehab centers in the country. We look forward, we are very excited about the potential of a spinal cord injury center located in the VAMC. We do not have one right now. They have great talents and skills in that area which we think we can match up with our expertise in rehabilitative medicine. And that is a partnership that doesn't exist as well today that will be enhanced by this program.

Mr. RYAN. That is great. Just let me how say how impressive I think the collaborative effort is and I am glad you guys are getting along just fine because we get along great on Capitol Hill here too.

I want to ask a couple of questions regarding the historic preservation, and I don't exactly know who to direct this to. As far as my own understanding, the sale of land, that money would be used to help fund this program, Mr. is it Samic?

Mr. SAMIC. Yes, sir, our understanding of the bill you have before you would be to establish a revolving fund I think with an initial $10 million, if what I have read is correct. It spends money to prepare land for transfer, incur the cost associated with that first. There is a set of priorities established and when that land is in fact or that facility is in fact sold, the proceeds go back into the kitty. So it is intended to revolve. Our concern, I think expressed by Mr. Nau and myself in his testimony as well, is that when you look at priorities under which those monies would be expended, preservation, historic preservation is last of the three that are listed there. In my view at least, I spent my 30 years in the Air Force on a financial business. Requirements always exceed available funds. And when you are the last set of priorities on almost any list, it is going to be very difficult to get to you. Environmental clean up alone I would think on some of these would be substantial.

Mr. RYAN. These facilities mostly hospitals, all hospitals, what are they?

Mr. NAU. Mr. Ryan, they are mixture of residences. Many of the veterans for which these were originally built, Civil War veterans, by the time they came online were getting older, their homes. You heard about one church, medical facilities in the terms of the turn of the 19th to 20th Century. So it is a mixture. They are campuses. As I said, most of them are now historic districts so it isn't a single facility. They were built to become a home.

Mr. RYAN. And what would they become after we preserve them? Would they be museums? Would they still be working facilities to some degree?

Mr. NAU. I think there are as many options as there are business opportunities. These buildings don't need to be torn down. As the General said, this fund could be used to stabilize them and have the community come in and create private sector health facilities, low-income housing, any number of business opportunities. This isn't the first time the government has de-assessed any type of facility and had it become a functioning economic engine for those communities. We don't need to go build these buildings again. We simply need to maintain them and then have a good adaptive reuse for them.

Mr. RYAN. I am wrapping up here. I think it is a good idea. I am from an older community myself and I think projects like this have enormous value, just one piece of a puzzle in a local community, especially smaller communities where it would have more of an impact than in a huge city. So I want to commend you for going down this road. We are dealing with a lot of issues here with funding for health and benefits and things like that. So just so you know the kind of competition you are up against, which I am sure you do. But I think there is enormous value in this kind of program for local communities so I commend you for your work and we will see how things play out. Thank you.

Mr. Chairman?

Mr. BEAUPREZ (presiding). I thank the gentleman. Mr. Moran?

Mr. MORAN. Thank you, Mr. Chairman. Thank you very much, Mr. Biro and Mr. Brimhall. Kansans care a lot about what goes on in Denver. It somewhat pains me to say that but it is the truth. And in fact I have always wondered who the politicians were that

gave away a good chunk of your state, the Kansas Territory used to include as far west as Colorado Springs. And somehow over the course of time, I don't know whether we gave up, I guess in the position I am in I should say we gave up, we discarded part of the territory and left it to Colorado.

But many veterans in our state and many patients, who are not necessarily veterans, rely upon Denver for their medical care. Ambulance services, air flights go west in much of my district. And so I also join Mr. Beauprez and others in praising the collaboration that is ongoing between the VA and the University and the medical providers in the Denver area.

Mr. Biro, as you know, I have great interest in trying to provide greater access for veterans who live in rural western Kansas. And you and I have had conversations, and I appreciate your willingness to come and meet with my veterans and look at some health care facilities in western Kansas. What caught my attention in Secretary Principi's testimony was the indication about the VISN director's ability to bring projects to the VA here in Washington in regard to CBOCs. And, as I understand the CARES Report, your VISN, of which six Kansas counties are a part, has three priority CBOC projects that will in some fashion be underway in the future.

And I just wanted to hear you confirm or at least express your understanding of what authority you have beyond the three CBOCs that are already in the CARES Report, what kind of process do you envision in looking at other opportunities? And is what the Secretary said this morning the way it has been described to you and to other VISN directors?

Mr. BIRO. Yes, what the Secretary described is how it is going to work. We have three CBOCs. They are pretty small. One is in Utah, two in Montana that we intend to get going within the year. After that we will again develop a list of other places that need to have CBOCs and we will follow the procedures that are established and then work through that list as the usual variables that come into being, mainly money, that we will move through that list as quickly as possible. And so know that western Kansas is an area, I am driving out there, it is 3 hours from Denver. So I will be very sensitive as to that traveling distance.

Mr. MORAN. And we are glad to know that you are driving. It will portray the distance that many Kansans travel unfortunately on a regular basis. We have been through the CBOC process in Kansas in the congressional district that I represent on three occasions now with VISN–18 in Kansas City. So I look forward to working with you as you proceed to try to better meet the needs of veterans across your VISN.

I would only reiterate what I indicated to the Secretary, which is that the criteria seems to me to be balanced between distance, which is significant, and density of veterans, which is less of factor in your calculation, the VA's calculations. But they are both equally important and in some fashion it seems to me the VA has to recognize that even though there is not a huge density, a large number of veterans, the inconvenience, and in fact that is way too shallow of a word, the inability for many veterans to access health care exists because of that distance even though there may not be a lot

of them and they have the same rights or are entitled to the same benefits as men and women who served our country.

I also would reiterate something I have pointed out to the VA before, when we do the accurate—when we do a count on the number of veterans in the area to be served by the CBOC, one of the things that has been unclear to me is whether the VA has counted the veterans in three states. A VISN in the northwest corner of Kansas would serve veterans in Colorado and would serve veterans in Nebraska.

And I have asked this question a number of times. When we look at that density number are we sure we are counting veterans in that three state area. And so as you work through this process, as we work together, I just again would bring up the issue that I think we need to make certain that we are counting all the folks who would benefit from that process even though they live in a three state region.

And I thank you for being here, your testimony, and look forward to working with you in the future.

Thank you, Mr. Chairman.

Mr. BEAUPREZ. I thank the gentleman. If I may, I would like to put forward a few questions to the panel myself. First of all, to President Brimhall, there has been a lot said, mostly by me today, about the great project out at Fitzsimons but let's probe just a little bit a couple of other things. If all goes forward as planned, we are talking about a very long-term land lease. You might explain to the committee why a land lease as opposed to purchase of the land or some other arrangement. And, frankly, if the University is being so gracious in making this land available at what I think is going to be a reasonably favorable deal, what does the University get out of this? Why are you so intent on the VA being your tenant?

Mr. BRIMHALL. Mr. Beauprez, the answer to the first question is a bit technical but the land, when the base realignment and closure process was completed and we made application to get the land, the land was conveyed from the Department of Defense to the Department of Education. It was then conveyed from the Department of Education to the University of Colorado under the terms, under a public benefit conveyance, which means that it was available to the University of Colorado as long as it was used specifically for educational purposes and that conveyance was a 30 year process. At the end of 30 years, the University has it without any covenants.

And so because the University has that land and it is under that covenant, it belongs to the University and therefore will require a lease to the Department of Veterans Affairs. That lease is not a problem. We have talked with the Department of Education about it. They are okay with it.

But the lease is the mechanism that needs to deal with the acquisition of the land. And the only thing we are dealing with now is, as Dr. Biro said, is to make sure that we have the authority to enter into that long-term lease, 75 years from the VA standpoint, not a problem from our standpoint. We can enter into a lease that long.

Why would we make this land available? It is very precious land. It is our home. It is our future for all our programs for as long as

we can predict. And when we prioritize who would get access to the land, that priority is made upon several criteria. One is who are the best partners? The VA is a crucial partner to us. The Children's Hospital is another one.

And so first of all, who are the best partners? Second is can we gain economies of scale? If we bring a partner to the site who does what we do and we can have economies of scale and savings by working together, that gives us an economic reason for conveying the land or leasing the land as opposed to putting some other program there that might have some benefit.

So the reason that the University is willing to do this is to maintain that very important partnership and because of our expectation that we will get economies of scale and therefore operate more efficiently.

Mr. BEAUPREZ. Mr. Biro, stay on that point for just a little bit because some of the testimony we have heard in the past in front of this committee about these kind of relationships that was alluded to just moments ago by the full committee or the subcommittee chairman, Mr. Simmons, is this relationship that exists. Now there has been a longstanding VA/University of Colorado relationship. In this case, I am going to make an assumption that that relationship can continue to be good. We are now bringing in a third partner. But some of the VSOs expressed concern, at least initially, I believe we have crossed that hurdle, that when you are getting in partnership, in bed, if you will, with a great big partner here, how can you make sure that the health care that we all want for our veterans remains priority number one and that you don't get relegated to some lesser seat on the bus?

Mr. BIRO. Well, one, when I talk to veterans' service organizations, I make three personal promises to them and I will make it in terms of this project here. One, that the quality of the care that they receive in our VAs will be second to none and that is non-negotiable and we will stand up to any comparison. The comparison will be there. What I will tell them is that the care that they get in our tower is exactly the same care that they get at the University of Colorado Hospital across the way. And I will emphasize that over and over again.

Two, that we maintain and expand services. This process will not go backwards. We will be going forward when we do this. And, third, that each and every veteran will be personally satisfied in the services that they receive at our facility. And that is a personal promise. And you may ask me how can I say that, I can just say because I say it and I say it over and over. I have said it for 5 years going on six that there will be personal satisfaction.

So that is just the standard. We set a standard. Our care is second to none. That is the first thing we look at and we will continue to do that. There are a lot of different ways of doing that but that is where we start and that is the way we continue.

Mr. BEAUPREZ. For both of you gentlemen if you would explain one other thing to me. One of the concepts that was first presented to me that made me think this is something I want to look at was this economies of scale business. In fact, I think there is an underlying assumption that over a period of time, as compared to renovating and trying to operate the old facility, this new facility will

essentially pay for itself if you will, that the economies of scale, the operating efficiencies are that significant. Would both of you opine on that for just a moment?

Mr. BIRO. Sure, just quickly, with everything Mr. Brimhall has said, it is a win/win we will do it. We are talking everything from laboratory to warehousing to environmental services to clinical services. Anything that we can look at where, and I have laid out, where we either break even or save money, we are interested in talking about. And he said the same thing.

Mr. BRIMHALL. Thank you. Congressman, health care facilities are the most expensive facilities you build today. We use a rule of thumb, million dollars a bed. That is $300 a square foot to construct these facilities. They are the most expensive facilities today you can construct. If for example we need 20 ORs, the Denver Veterans' Affairs Medical Center needs 15 ORs, that is 35. But if together we only need 33 because we can share, then we saved a couple of million dollars right at the get go off the construction costs.

Now that is just a simple cartooned example of the type of savings that one gets at the beginning for the construction. But, as Mr. Biro referenced, if you could share things such as laboratory equipment, which you can run 24/7, and not have duplications running 8 hours a piece but rather have a common piece of equipment running 16 hours and you bring the DOD in on that, then you start to get enormous savings in the actual operations of it.

Now, as I have said before, the really remarkable thing about this is that everybody wins. And if we can identify those proper areas, and that is what we are discussing, for these types of savings, these savings will accrue to all of us and to our constituents for a very long period of time and we have high expectations that this will happen.

Mr. BEAUPREZ. Mr. Biro, what happens to the old hospital, the one at some point here in the future you are going to be vacating?

Mr. BIRO. I am waiting for guidance from central office and Mr. Principi on a process that will look at that property. I believe they are going to use a consultant to look at the property for its highest and best use that will benefit veterans. That is what we are looking at is some use of that property to benefit veterans. Obviously, that can go two ways. One, some sort of service remains there or, two, as the topic of this meeting or this hearing is that this money from the sale that could be used to subsidize the new facility.

Mr. BEAUPREZ. And I will use that as a bit of a segue to Mr. Samic and Mr. Nau. I don't know that this facility necessarily has great historical significance but, as we think about, and that is a personal passion of mine, I in a past life renovated some old buildings and used them for modern use and I am fairly proud of that actually. I am thinking that one of the challenges of any legislation we put forward back here to accommodate the end that both of you seem to be seeking, and of which I would have some sympathy for, would be to do what we don't do very well at the federal level and that is build maximum flexibility into that kind of legislation, multiple options.

Am I thinking correctly? You referenced Mr. Turner's bill, H.R. 1762, I will confess to not being intimately familiar with it just yet, but does it contain that kind of flexibility?

Mr. NAU. Yes, Mr. Chairman, it does. It certainly encourages partnerships for adaptive re-use of these facilities. There are examples all over the country. There is an example of the National Trust for Historic Preservation partnership with the Army as a result of some of the BRAC deactivations over the past 20 years. Congressman Turner's bill probably does as good a job as I have seen in encouraging those kind of partnerships and brings in the private sector. The private sector is where the capital investment needs to be.

What VA needs to do is simply maintain the facility so that an investor, be it a 501(c)(3), a for-profit institution or anyone else, doesn't have to go in and look at a damaged building. And our experience at the Advisory Council, and we worked with the CARES Committee, they actually came in, made a presentation to a formal Council meeting of ours in 2003. We have had particular focus on this activity because of the 1,900 historic facilities that are involved in this.

So we are familiar with it, and I believe that Congressman Turner's bill definitely points in the right direction on how to use these facilities so that the communities in which they exist have the economic development opportunities. Otherwise they become a bit of a problem and they go from an asset to a liability.

Mr. BEAUPREZ. General Samic, anything to add to that?

Mr. SAMIC. Yes, sir, let me say first thank you for being the first we heard today speak about historic preservation.

Mr. BEAUPREZ. I am getting older. It is very important.

Mr. SAMIC. And as well when you hear the testimony for disabled American vets and the paralyzed vets, as well as Secretary Principi, all of them speak of this in a positive term, speak first to the flexibility issue. It is important. You have got priorities established inside the law, the proposed law as it is written now and that is fine. If in fact you intend to have some preservation funded from this piece of legislation, our recommendation is that you establish some kind of floor. It may be not a large number but it is significant in the fact that it is there. And I think what we are really looking for here is seed corn, to be honest with you. There will not be enough money to do both of these things. You heard Secretary Principi say he doubts this year he is going to be addressing Category 8 with the funds he has got let alone preservation.

But when we go address people at the standard register, Nexus/Lexus, whoever we are talking to in the Dayton area, these are businesspeople who have got stockholders who are looking for a business case. Preservation goes so far, patriotism goes so far but a business case has got to be made. We are trying to get something in our particular case which will be the western underpinning of a historic corridor that already starts now with the Houghman Prairie where the Wright brothers flew through the Air Force Museum, downtown to the Wright Dunbar district out to the western side of town. It fits in the image and the vision that the city has got if we can just get the seed corn going. I think that is what we would love to see this legislation provide is that seed corn.

Mr. BEAUPREZ. Thank you. Any further questions, Mr. Moran?

Mr. MORAN. No, sir.

Mr. BEAUPREZ. Well, if not, then I will dismiss this panel. It has been an exceptional panel, and I thank all four of you gentlemen for your contribution.

I call in place our third panel, which consists of representatives from our renowned veteran service organizations. The subcommittee welcomes Mr. Richard Jones, national legislative director of AMVETS; Mr. Peter Gaytan, principal deputy director of The American Legion; Mr. Rick Weidman, director of government relations for the Vietnam Veterans of America; Ms. Joy Ilem, assistant national legislative director of the Disabled American Veterans; and Mr. Richard Fuller, national legislative director of the Paralyzed Veterans of America. The Veterans of Foreign Wars will be submitted testimony for the record. And I hope I have not butchered your names too badly.

STATEMENTS OF RICHARD JONES, NATIONAL LEGISLATIVE DIRECTOR, AMVETS; JOY J. ILEM, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; RICHARD B. FULLER, NATIONAL LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA; PETER S. GAYTAN, PRINCIPAL DEPUTY DIRECTOR, THE AMERICAN LEGION; AND RICK WEIDMAN, DIRECTOR, GOVERNMENT RELATIONS, VIETNAM VETERANS OF AMERICA

STATEMENT OF RICHARD JONES

Mr. JONES. Thank you, Mr. Chairman.

Mr. BEAUPREZ. I got Mr. Jones okay, I suppose.

Mr. JONES. I am sorry, sir?

Mr. BEAUPREZ. I suppose I pronounced your name correctly?

Mr. JONES. Jones is correct, sir. We were all named Jones until we fell from grace. That is what I am told.

Mr. BEAUPREZ. Well said, and it is good to see you again, sir. Go ahead and proceed.

Mr. JONES. With some exceptions, Mr. Chairman.

Mr. BEAUPREZ. You must not have talked to my mother. She would correct you on that one.

Mr. JONES. It is a pleasure to present our views on this draft legislation to authorize capital leases and address related matters. AMVETS supports the numerous leases authorized for contract in the draft bill. These facilities will help maintain VA congressionally-mandated missions of sustaining health care delivery for American veterans, both regionally and demographically. We have learned important lessons over the years, that the establishment of health care clinics helps pave the way toward a comprehensive solution to veterans' health care needs and strengthening clinical services, as this draft legislation would, should help continue VA's efforts to attain the quality health care programs that will significantly affect veterans' care.

We trust, of course, that Congress and VA will also work together to provide a health care system, a dynamic health care system that meets the specialized needs of veterans as well.

The draft bill also contains language to establish a Department of Veterans Affairs' capital asset fund to receive proceeds from a disposal of VA real property by sale, transfer or exchange. Proceeds

retained within the fund would be used for the cost of actual or planned disposals of real estate, including demolition, environmental clean up, necessary improvements, transfers and exchanges, and administrative expenses. And the fund would be available for use to improve non-recurring VA capital projects.

Finally, the draft language terminates the nursing home revolving fund to transfer remaining funds to the capital asset fund and authorizes to be appropriated to the fund $10 million.

AMVETS supports these provisions because they would facilitate VA's completion of transfers and disposals and the provisions provide an orderly process of notice, public hearings, receipt of fair market value for disposals and transfers while at the same time providing a funding mechanism for improving current facilities.

AMVETS is of course pleased to see the proposal contains language to use funds for the purpose of maintaining and preserving historic properties. As a co-author of independent budget along with DAV, PVA, and VFW, we of course encourage VA to work with nonprofits and other groups interested in protecting VA's portfolio of historic properties. There is a need for these partnerships. VA certainly cannot do it alone.

Mr. Chairman, we applaud your holding the hearing. We thank the subcommittee for extending us the opportunity to present our views. And we look forward to working with you and others to strengthen, enhance and improve the earned benefits for our nation's veterans and their families.

Thank you, sir.

[The prepared statement of Mr. Jones appears on p. 117.]

Mr. BEAUPREZ. Have I got that close to right?

Ms. Ilem. Thank you.

Ms. ILEM. Ilem.

Mr. BEAUPREZ. Ilem, okay, thank you. I am sorry.

STATEMENT OF JOY J. ILEM

Ms. ILEM. Mr. Chairman and members of the subcommittee, thank you for the opportunity to present the views of the Disabled Veteran Americans on proposed legislation concerning property management at Department of Veterans Affairs facilities. Like many DAV members who have suffered catastrophic disabilities as a result of military service, many of the men and women serving today in our Armed Forces in Iraq, Afghanistan, and other trouble spots around the world will need and depend on the VA health care system for years to come. For this reason, preservation of the integrity of the VA health care system and its specialized programs are of the utmost importance to the DAV.

Addressing the infrastructure, renovation, and modernization needs, building safety concerns, and veterans' access issues requires innovative ideas and appropriate management of VA facilities. The implementation phase of CARES is critical to resolving these matters. Therefore, we are pleased to support many of the provisions contained in the draft legislation considered today.

Currently the time-consuming process to implement VA's authority for enhanced use to lease property dissuades many interested parties from entering into such an agreement and VA officials from considering this option as a potential investment opportunity. The

Department of Veterans Affairs Real Property and Facilities Management Improvement Act of 2004 seeks to improve VA's authority to manage the sale or lease of its physical structures. This proposed measure would eliminate the nursing home revolving fund, establish a capital assets fund. DAV fully supports this provision that would allow funds derived from the lease or sale of VA property to be reinvested for the improvement of other VA facilities.

However, we want to ensure any funds received from the sale of property are used only for the intended purpose. Specifically, VA infrastructure reinvestment.

One major concern we have is that the Office of Management and Budget and the congressional Budget and Appropriations Committees will propose that the funds received from the sale of VA properties be offset in the annual appropriation VA receives. For CARES to be successful, VA must be able to retain any funds from the sale of properties to pay for necessary infrastructure improvements. Likewise, VA should continue to receive funds from major and minor construction as well as spending for non-recurring maintenance to compensate for the years of neglect of VA infrastructure needs.

DAV also supports the provisions contained in the proposed measure concerning the establishment of new community-based outpatient clinics. In many locations, CBOCs will improve access to health care services for veterans and lead to an overall enhancement of services.

We thank the subcommittee for including in the proposed legislation provisions that would allow capital asset funds to be used for preservation of historic properties. This provision would help VA to begin address the need to stabilize, preserve and re-use its nearly 2,000 historic buildings. Using the resources from the capital asset fund to renovate historic structures would also help to achieve these goals and make them more attractive properties for enhanced use lease and other adapted measures.

We are also pleased about the inclusion of provisions that would require VA to provide Congress with a plan and certification every 6 months of its compliance or non-compliance with the provisions relating to staffing and capacity levels for extended care services. This provision will clarify VA's commitment to meeting the needs of veterans seeking long-term care services.

In closing, we believe this draft legislation represents a good first step in addressing the very complex issue of facilities management. And we look forward to further discussion on this important proposed measure.

Mr. Chairman, that concludes my statement, and I will be happy to answer any questions you or members of the subcommittee may have.

Thank you.

[The prepared statement of Ms. Ilem appears on p. 121.]

Mr. BEAUPREZ. Thank you very much, Ms. Ilem. Mr. Fuller.

STATEMENT OF RICHARD B. FULLER

Mr. FULLER. On behalf of Paralyzed Veterans of America, we are pleased to testify before the subcommittee today. Mr. Chairman, this is a time for all of us to be very vigilant with the CARES proc-

ess beginning to unfold and VA, as in the case of this legislation seeking ways to re-order their infrastructure, we need to make certain that the commitment to veterans remains very clear. With CARES we need to be certain that any decision made regarding VA facilities is made with the present and future interests of veterans in mind.

As a case in point, the CARES Commission routinely stated that its goal was to expand the specialized care programs in spinal cord injury, adding more centers and beds. And yet when their report came out, they qualified that recommendation by stipulating that the expansion would be based on future validation and a call for potential new spinal cord injury centers. This said, despite the VA's own studies and projections that the expansion was fully justified through scientific analysis of the spinal cord injury population. Rightly concerned, PVA has met with Secretary Principi, who has agreed with us that the CARES language was wrongly written and would be corrected.

The ultimate goal of the CARES process remains the enhancement of services to veterans. We should not allow any back-tracking on this point, either through the CARES process or any facility realignment plan. Great care must be taken to ensure that the value and equity in VA's physical property is not squandered.

With that caveat, we believe that the legislation before the subcommittee does provide the VA with improved flexibility in leasing unused or under used properties. Likewise, it facilitates the process by which VA may dispose of properties ensuring that the proceeds are used to the benefit of the veteran population.

PVA strongly supports the creation of the capital assets fund, a provision which would allow VA to keep the equity and the income from property it conveys and, in the spirit of the CARES process, use those proceeds for the improvement of health and the benefit delivery of veterans.

We have two areas of caution, however. First, VA with the proper congressional oversight must ensure that VA receives fair market value and appropriate leases for these properties. We don't want fire sales going on for VA properties. And, secondly, we do not want to see VA major and minor construction funding or non-recurring maintenance budget line items offset by capital asset fund disbursements. Capital asset funds collection must be over and above the regular appropriation for these line items.

And, finally, Mr. Chairman, we would like to actually commend this subcommittee for including historic preservation of VA structures as a recipient of capital asset funding. The fiscal year 2005 Independent Budget co-authored by AMVETS, DAV and PVA and the Veterans of Foreign Wars makes a very direct recommendation on the protection and preservation of VA's extensive inventory of historic structures. The Independent Budget recommended a $25 million VA fund for fiscal year 2005 to be used to stabilize, preserve and re-use appropriate VA historic structures. Funds should also be provided to make grants to local and national nonprofit organizations for the preservation activities related to VA facilities. The CARES Commission Report also recommended that VA move to address this issue.

And without objection, I would like to submit The Independent Budget historic preservation recommendations for the record, without objection.

Mr. BEAUPREZ. So ordered. Thank you.

[The provided material appears on p. 130.]

Mr. FULLER. VA owns almost 2,000 historic structures, many are suffering from neglect and deteriorate further every year. VA has a moral responsibility to maintain these examples of our national legacy. We share in caring for the American veteran. The Department is bound by other federal statutes requiring it to care for these structures as well. Other federal departments and agencies have come to grips with this problem, finding alternative uses or divesting themselves of historic properties through leasing or sale.

VA, if given the incentives, can do the same. VA must inventory its historic structures and establish broad classifications regarding their current physical condition and their potential for adaptive reuse. The capital asset fund is a logical source for renovation, funding or stabilization for enhanced use leasing and to help VA turn may of these structures from liabilities into assets. We strongly recommend that this legislation be amended to make historic preservation one of the optimum goals of VA's enhanced use leasing authority.

In closing, Mr. Chairman, I would just like to say that we have been working on this historic preservation issue for as many years as I can remember and dealing with the VA on this issue has been, to put it nicely, a challenge. I think that the leadership of this subcommittee can demonstrate, particularly with the CARES process unfolding, that there are ways to deal with these properties providing great opportunities and not problems for the Department. We need to fine-tune this legislation very carefully to see that that incentive is provided.

That concludes my testimony.

[The prepared statement of Mr. Fuller appears on p. 124.]

Mr. BEAUPREZ. Thank you very much, Mr. Fuller. Mr. Weidman.

STATEMENT OF RICK WEIDMAN

Mr. WEIDMAN. Mr. Chairman, on behalf of Vietnam Veterans of America, I want to thank you for the opportunity to appear here today and salute the leadership of this committee yet once again. We support this draft legislation with a few refinements, but do think we need to comment about the process that produced this particular list of 17 properties for enhanced use.

VVA is deeply committed to the concept of stewardship and stewardship in the Biblical sense that you leave both the physical structure as well as the organizational capacity better than when you found it. Our first national president was one of the veterans featured in the famous 1970 Life Magazine issue on the Bronx VA. It was that story that led to the momentum of the demolition of the old VA and construction of the fine, modern facility we have today in Bronx, New York.

The concept of CARES is something we fully endorse but the problem is that the devil is in the details. The old country saying is, "You can make a silk purse out of sow's ear but only if you start with a silk sow." And that is the problem that lies therein when

it comes to the CARES process. There was no proper needs assessment prior to the beginning of the CARES process. In other words, they took what was after 7 years of devastating cuts, particularly in the specialized services and most particularly in mental health, and used that as a snapshot figure on which everything else was based. That is number one.

Number two, then they applied a civilian formula that was designed for healthy people, middle-class people who could afford a PPO or a HMO produced by Millman Associates. It did not take into account any of the specialized services, any of the wounds of war, from spinal cord injury to PTSD to general mental health to prosthetics to you name it. And so then it produced the original draft product that was supposed to be the basis for the building of the plans at the VISN levels. At least 11 VISNs had no consultation whatsoever with the veterans community in their VISN prior to submitting their particular segment of the plan to the national office. At least five or six additional ones it was basically a dog and pony show. They all assured the under secretary for health that they in fact had done it, but they did, as Daisy said in The Sun Also Rises, they did a, "Let's not and say we did." So the problem is it was flawed from the outset because there wasn't a proper needs assessment of what really was the need out there.

And, number two, what does that mean in terms of projections based on this being a veterans health care system as opposed to a general health care system that happens to be for veterans. And that led to many, many errors in the conclusions of the draft plan, which was then given to the Honorable Everett Alvarez and his distinguished colleagues. We have tremendous faith in Everett Alvarez. Frankly, personally, I believe he is one of the true American heroes, not just for what endured and went through in military service but for how he has spent his life since he returned to the United States. They did a great job of correcting many of the most egregious mistakes of the draft plan. The Secretary, as he accepted it, made more adjustments and knocked off more of the errors.

The problem that we have here however is the plan did not take into account long-term care and it did not take into account neuropsychiatry or the mental health needs of veterans. It is no accident that eight of the facilities that were targeted for closure were primarily mental health facilities, even ostensibly though mental health wasn't in the plan. So we have need for a fundamental overhaul of that plan for the future before it becomes the basis for strategic planning documents in the future.

I would point out of all of the things that Secretary, and incidentally we strongly support this Secretary, we think he is doing a fabulous job with limited resources as is his deputy. The problem there is sometimes he doesn't always get the straight scoop. None of those boards and those committees that were listed in the official testimony from the VA have any representation from the veteran service organizations whatsoever.

It is not that we are trying to tell people how to do their job but we can often shed perspective and light that help the VA from going wrong, whether it be from the mental health strategic plan or the overall long-term strategic planning group. And there has been no informing of the veterans groups about the status or what

is going into those plans at this particular point. This kind of paternalistic behavior of not consulting with the veterans' community nor with the local community nor with the Congress is what has gotten us into such difficulty in the past.

I would note that, because I see I am running out of time, sir, that when it comes to the capital asset plan we very much agree with that concept and applaud you for approving it. We would offer a caveat however. When you take the nursing home care asset fund and lump that together with an overall care asset fund, nursing home care and the development of long-term care for veterans as provided for in the Millennium bill may well get totally glossed over and none of the proper investment happen in that area, number one.

And, number two, we would also suggest to you that instead of authorizing $10 million to start this fund, you should be thinking in much larger terms. We believe that a billion dollars a year over the next—for the rest of this decade is not near enough. That is just for the next 4 to 5 years in order to adequately begin to make up for poor stewardship of so many years and will take at least $10 billion.

So in regard to historic preservation, we commend you for including that in the bill and believe that had many of the facilities that we currently have today been kept up and designed for re-use, they in fact would be in much better shape today and we wouldn't have to use them as excess property, if you will.

Mr. Chairman, that concludes my oral remarks, and I wish to thank you very much again for allowing VVA to appear before this distinguished body.

Mr. BEAUPREZ. I thank the gentleman. I thank all members of the panel. For the record, Mr. Gaytan of The American Legion could not remain due to a conflicting meeting, but The American Legion's statement will be made part of the record of this hearing, without objection, as if it was given. Hearing no objection, so ordered.

[The prepared statement of Mr. Gaytan appears on p. 131.]

Mr. BEAUPREZ. If I might a general question of all on the panel and, Mr. Weidman, I appreciate your very direct comments as you concluded your testimony about your concerns with the CARES Report. Now all VSOs it is certainly apparent to me have followed this CARES process very, very carefully. And on behalf of your specific organizations or other VSOs who aren't represented today but obviously, I am going to say obviously, leave it to you to comment, that you interact with, what summary comments, if any, might you have to make to help us complete our understanding from the VSOs where you stand relative to the CARES Report from the point of view of the veterans you represent?

Ms. ILEM. I would just say on behalf of DAV, we were supportive of the CARES process. We think it needs to get moving. We want to see things start to happen but we want the focus and the emphasis of course to be on the enhanced services. And we were distressed about some of the things within the CARES process, especially about the omission of long-term care and some of the mental health things that happened.

But VA has made a commitment to try to resolve the mental health issue. That is ongoing and hopefully that is going to be included in their strategic plan. And the long-term care issue must be addressed and resolved. It is a complex issue but many veterans are in need of long-term care.

So that was distressing, that is such an important piece was not really considered as part of this at this time just due to time constraints and wanting to get this going. But we do appreciate that a lot of hard work went into the Commission Report and the VSOs, we have all been there through this so we want to see now through the implementation phase. There needs to be again strong information being put out there, both to you and to us, the VSOs and other interested parties, about what the VA intends to do. That is where again we have kind of been cut off now since the report came out. We would like to see more interaction between the VA and the VSOs just to make sure what direction they are going in and do we agree and do we think moving in a timely manner.

Thank you.

Mr. BEAUPREZ. Thank you. Anyone else? Mr. Fuller?

Mr. FULLER. Mr. Chairman, as I stated in my oral remarks, we have been following the CARES process very, very carefully, particularly because of the specialized services in spinal cord injury that the VA is world-famous for. Indeed we were very pleased that they saw the need and said that there were gaps in coverage for spinal cord injury in various different places. Denver is one of them where a new center is going to go. Then, all of a sudden, the report came out and it wasn't really quite firm. We have that firm commitment now from the Secretary.

But I think, as with the entire CARES plan, there is a lot of paper there with a lot of recommendations on that paper, with a lot of things that can either help people or potentially hurt people too. Overall, I think the aim of CARES was to help people. The problem is that this process is going to unfold itself over a decade, and is going to overtake this Administration or the next Administration, this Secretary, the next Secretary, the next Secretary, the next Secretary after that. And these kinds of reports have the ability to sit on a shelf some place when other priorities become a factor.

Noting the future generations of service on this particular committee, we need to be able to pass that torch down properly. If you say that you are going to close something you need to build something first before you close that. Let's make sure that you build that thing before you close the other, both to maintain the continuity of service but also a continuity of the promise and the promise in which Tony Principi has constantly stated is the objective of the CARES process, to improve services for veterans. So I am sorry if I sound a little cynical, but I am.

Mr. BEAUPREZ. I am going to guess the voice of experience, perhaps. Mr. Weidman?

Mr. WEIDMAN. Yes, sir, Mr. Chairman, a bit of history on the CARES process. After the VISN–12 fiasco and we were brought in at the last minute to meet with the contractor who has been—was different than they had later, what was the first contractor they had?

Mr. FULLER. Oh, I don't know.

Mr. WEIDMAN. Anyway, we brought up the issue of specialized services and taking of military history in that this is a veterans' health care system. And we were informed at that point that it was too late to bring this up and don't get upset at the consultants. To which I replied to an assistant secretary over there, "We are not upset with the consultant. We pay you in six figures a year. Where the heck have you been? Why haven't you brought us in before and why haven't you informed this individual that this is not just another general health care system? We have specialized wounds and diseases that you would not see and, please, God, may the civilian population of our great country never see the kinds of wounds and illnesses and conditions that America's veterans have, particularly those of us who served in a combat theater of operations."

But we were informed by then Deputy Secretary McKay of their decision regarding VISN–12. Now he had worked very hard on comments as had all of our colleagues and not a single comma was changed when the final regulation for VISN–12 was changed, which eliminated 146 additional mental health beds on top of what had already been torn out.

The point about it is this. After that -- incidentally, what he said to us was, "We admit the process was very flawed but we have full confidence in the results." Now that one threw me for a bit because I couldn't figure out how in the world if you know the process is a mess can you have full confidence in the results? And it was subsequent to that that we begin meeting the veteran service organizations at one—actually it was the PVA and we started meeting between ourselves to try and figure out how is a better way to make this process work. In the meantime, we had gone to, a number of us, to the Secretary and said, "This is not working." And it was subsequent to that that he brought in Bob Coy and that he brought in a number of other folks to try and help ameliorate the process and brought in Fred Malvers from VISN–2 and started to try and get input from the veterans community.

The problem is that the Millman people never would listen or even try to understand what we were talking about. And the process at every single turn we were asked for input when it was "too late to change it, too late to change it, too late to change it." And the question that we continued to ask if there is not time to do it right the first time, exactly when do you think we are going to get time to do it right?

And that is the problem that we have. The legacy that is going to be left for the subsequent administrations, as you pointed out, Mr. Chairman, is going to be that basic core process about how do we assess where we are, where do we need to go, and how can we get there, both in terms of what happens in VA facilities and what physical facilities do we need in order to facilitate that.

I will begin right here with the graph that the Secretary showed this morning. You look at the overall veterans population and you will see a decline but look at the number of enrolled in that blue line. That blue line is not figured on who is statutorily eligible to use VA. That is figured on Categories One through Seven.

If in fact you want to change who is statutorily eligible to use VA health care, then let's do it above board. Let's offer the bill to

eliminate and take away the right to use VA from those above that certain threshold and let's have that free and open debate. What is happening now is it is being done through the back door. And we object to that quite strenuously. And that is just one example.

So whether it is in this legislation or in the future, Mr. Chairman, we cannot urge you too strongly to address those needs of stating explicitly that the Congress believes that this needs to be a veterans health care system, that this process needs to be thoroughly studied and the methodology shared with the Hill before we move toward the strategic plan, that it be done right from the outset instead of trying to re-do it later because later never comes.

I know that was a long answer, and I thank you for your indulgence.

Mr. BEAUPREZ. Appreciate the gentleman's comments.

Mr. WEIDMAN. But we think it is really important.

Mr. BEAUPREZ. Mr. Jones, quickly, if you would. I think I have imposed on Mr. Moran's time considerably already.

Mr. JONES. Yes, sir, AMVETS has a forward view of the process. We recognize the stage we are in. We encourage Congress and VA to work together to rebuild an effective, efficient system that gives value to the resources that are being used to provide quality and timely care to American veterans. We think that what you have before you, the draft bill, helps in that process.

Thank you, sir.

Mr. BEAUPREZ. Thank you, Mr. Jones. Not seeing any Democrat members, I would ask the counsel, though, do you have any questions on behalf of your members?

Ms. EDGERTON. Thank you, Mr. Chairman. This will be brief. I just want to know how you all prioritize the needs for funding the CARES initiative versus if we have to have choice here, how does it fit into medical care? That is I think what we are going to be having to figure out in the near future.

Mr. JONES. The first priority should be to eliminate the backlog of patients, to make sure that care is given to those folks waiting for care. Following that, we should proceed forward as accelerated as we can in the CARES process, get these new systems in line.

Mr. BEAUPREZ. I might ask if any of the other three have an answer that varies from the one just given? No?

Mr. WEIDMAN. You can't separate the two, sir. You can't deliver quality medical care in a facility that is falling to pieces so it is going to have to be somewhat balanced, if you will, as we move forward because of the limited funds. But it all comes back to the dough to make it go, sir.

Mr. BEAUPREZ. Thank you. Mr. Moran?

Mr. MORAN. Mr. Chairman, thank you very much. Just a follow-up to the question I asked Secretary Principi, what do you see as a consequence to the VA from the war on terror, the soldiers now serving in Iraq and Afghanistan? Mr. Weidman, you talked a lot about mental health. So my question is really twofold, what do we see as far as numbers, demands upon the VA system? And then, secondly, what kind of care do you anticipate being required as a result of servicemen and women's health care needs being met by the VA once they return?

Mr. WEIDMAN. As the Secretary rightly pointed out, there are a many more catastrophic wounds, people who would have died in Vietnam, and I was a medic in Vietnam, who we would have lost are living now. And I go into Ward 57 up at Walter Reed pretty regularly and talk with young men and in some cases women with these really profound wounds and they are going to have a tough time. The VA in regard to some of the profound wounds is I believe will be there to take care of them. It is everybody else below that line and it is particularly those with mental health.

The concern with mental health has been there with us from the outset, that you all aren't prepared to do this correctly in all of health incidentally, when it comes to the environmental hazards, the DOD is still not requiring as a mandatory thing that all commanders have a pre-deployment physical and preservation of the tissue and blood sample as the law requires and to do the same within 3 days upon return of CONUS. And that is going to make it harder to track those diseases.

But when it comes to mental health, in the Memorial Day last year, not this year but the year before at the White House breakfast that the President threw for the veterans' organizations, General Myers is chairman of the Joint Chiefs of Staff and he is a life member of VVA and we know him because he comes to our meetings sometimes. And we were talking with him about and congratulating him on his terrific war plan that none of us would have bet a plugged nickel that we would take less than 200 casualties in the first active phase of the war.

His comment back was that we were lucky and that he had a great team. And he was troubled however, that is one of the reasons why this really is the greatest country on earth, our chief military guy was deeply troubled by the civilian casualties, which were much more than they anticipated, and also deeply worried about our troops because the fire power available to our folks on the ground had grown so exponentially from 1991 to 2003 that the amount of death and destruction they would wrought as they moved northward was so great and the death they saw and experienced and caused was so great that he was deeply worried about the mental health wounds, that the PTSD wounds were going to be deeper and more profound and probably have greater than any recent conflict, certainly in the first Gulf War and possibly even more than Vietnam.

And it turns out that it looks like that that is prescient, sir. The Army is not dealing with it very well. And, frankly, the VA, more than two-thirds of the organizational capacity to deal with mental health that existed in 1996 is gone. It is just gone. And we need to start reconstruction of that organizational capacity. And it won't happen overnight. We are not a warm and fuzzy group to deal with, certainly not Vietnam vets but not even the younger people. And it is going to be a very tough problem and it going to result in physiological acute illnesses that are going to cost a heck of a lot of more than to have treated the PTSD properly at the beginning because we are not gearing up for it, sir.

Mr. FULLER. I would just like to add very, very briefly, that we have been involved with ongoing discussions about the increased number in blast injuries and we are getting into traumatic brain

injuries, which we are seeing as a result of these blasts in varying different degrees. We have been talking with White House people about it. I know that Senator Graham has just introduced a bill over in the Senate which would authorize the VA to establish blast injury centers of excellence in the VA to work with this problem. With regard to a person who is in a HMMWV and gets blown up, it is very obvious is what has happened with this individual. You can diagnose that.

But the person in the HMMWV right behind him who wasn't necessarily particularly injured but was shaken up in some way as well all of a sudden comes back home, is exhibiting certain odd signs of behavior. People say, well, it is Post-Traumatic Stress Disorder or this, that or the other thing, and they don't really connect it with the actual blast injury itself. So we are working to work with DOD and VA to be able to coordinate the two Departments to address this issue.

Ms. ILEM. I would just add one thing. You might want to speak to the VA's Advisory Committee on Veterans with Serious Mental Illness. They have been discussing this issue. They are the front-line leaders that are out there. They have been talking about this issue at the last several meetings and there are real concerns about what they are going to be seeing and how they are going to be able to manage it within the VA and their ideas about coordination and cooperation between VA and DOD. I think you would find it very interesting.

Mr. MORAN. Thank you for that suggestion, Ms. Ilem.

Mr. JONES. The Secretary addressed several concerns during his testimony. One in particular is the concern about the higher rate of amputations due to the Kevlar protection, breast armor and the like, head injuries, and blindness. So these are areas where we need to be concerned as well.

Mr. MORAN. I thank you all for your comments. Mr. Weidman, a couple of things. One, the chairman of the Joint Chiefs of Staff is a Kansan. I am glad to hear you compliment him. Two, I offered an amendment on Tuesday to the Defense Appropriations Bill to once again tell the Department of Defense to conduct the pre- and post-deployment physicals. Unfortunately, it was not allowed on a point of order as legislating on an appropriations bill. But I do hope that we have once again highlighted what Congress told DOD in 1997 and what I believe the DOD told us they will do in testimony before this subcommittee over the course of several years.

And so again, we would want to work with you and others but I personally am very interested in delivering this message to DOD, abide by the law. And every inference I can see is no one admits they don't abide by the law but if you read what they say they do, they are passing out a questionnaire and if there are certain questions answered in a certain way, then there is additional follow-up. That is not a pre- and post-deployment physical as I understand it. It is not what I think they told me. And we will continue to beat the drum for that to occur.

And, finally, I only ask permission if I can borrow your sow and silk story? It would be one that I wouldn't mind using myself, it is a good one. I think that one works in Kansas, you are right. Thank you.

Mr. WEIDMAN. Mr. Moran, of course, sir. My words are your words, sir. And it is actually a folk saying, particularly in the South, that is an appropriate one.

I appreciate your efforts. I didn't know about that. In the future, please call on Vietnam Veterans of America. We worked very closely with Senator James Talent on the Senate side and also Senator Clinton on the amendment that was accepted on the Senate side that got weakened somewhat by committee staff, unfortunately, but it is better than we had before to set up the tracking, et cetera. And I look forward to following up with you to make sure that it stays in conference, sir.

Mr. MORAN. I would be happy to lend my efforts in that regard. I also point out that the gentleman from Georgia, Mr. Bishop, has a bill that once again tells the Department of Defense to do what they are told to do now 6 years ago. Thank you, Mr. Chairman.

Mr. BEAUPREZ. I thank the gentleman and have a follow-up question for him. I have some appreciation for how the pork industry is in Kansas. I am a little uncertain as to how the silk industry is in Kansas.

Mr. MORAN. I will leave the wit to Mr. Weidman.

Mr. BEAUPREZ. Well, this has been I think a rather exceptional hearing. For the record, we have statements from Representative Frank LoBiondo of New Jersey, also a statement from the Heritage Guard Preservation Society, to be inserted in the record, and without objection, that will be so ordered.

Mr. BEAUPREZ. One final comment. I was at least pleased, I think the skepticism, the concern that we all have I think is appropriate. I think as we go forward in what undoubtedly will be a lengthy process, it will require vigilance on the part of many future Members of Congress, future members of this committee, future individuals who will sit in the capacity of you all representing your various veteran service organizations.

But I expect with that kind of oversight and the commitment of people like Secretary Principi, we will continue down the path of better health care for all our veterans. I was pleased to hear in his testimony certainly a recognition of the need for addressing the issues of long-term care and of mental health. I think it is perhaps the era of service that he comes out of as well and knowing that we did not do everything we should have for especially our Vietnam veterans as they came home, that this is a particularly sensitive issue, important issue, obvious issue to this Secretary. I hope that we do move the ball forward and we make considerable progress on behalf of all of our veterans.

But I applaud you. Thank you for being with us today. And seeing no other action necessary of this subcommittee, I will declare this hearing adjourned.

[Whereupon, at 12:30 p.m., the subcommittee was adjourned.]

APPENDIX

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[DISCUSSION DRAFT]

108TH CONGRESS
2D SESSION

H. R. _____

To amend title 38, United States Code, to authorize the Secretary of Veterans Affairs to enter into certain capital leases, to authorize that Secretary to transfer real property subject to certain limitations, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

Mr. SIMMONS introduced the following bill; which was referred to the Committee on _____

A BILL

To amend title 38, United States Code, to authorize the Secretary of Veterans Affairs to enter into certain capital leases, to authorize that Secretary to transfer real property subject to certain limitations, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

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June 18, 2004 (5:00 PM)

1 **SECTION 1. SHORT TITLE; REFERENCES TO TITLE 38,**
2 **UNITED STATES CODE.**

3 (a) SHORT TITLE.—This Act may be cited as the
4 "Department of Veterans Affairs Real Property and Fa-
5 cilities Management Improvement Act of 2004".

6 (b) REFERENCES TO TITLE 38, UNITED STATES
7 CODE.—Except as otherwise expressly provided, whenever
8 in this Act an amendment or repeal is expressed in terms
9 of an amendment to, or repeal of, a section or other provi-
10 sion, the reference shall be considered to be made to a
11 section or other provision of title 38, United States Code.

12 **SEC. 2. CAPITAL LEASES.**

13 (a) AUTHORIZED CAPITAL LEASES.—The Secretary
14 of Veterans Affairs may enter into contracts for capital
15 leases for the following facilities, in an amount for each
16 facility not to exceed the amount shown for that facility:

17 (1) Wilmington, North Carolina, Outpatient
18 Clinic, $1,320,000.

19 (2) Greenville, North Carolina, Outpatient Clin-
20 ic, $1,220,000.

21 (3) Norfolk, Virginia, Outpatient Clinic,
22 $1,250,000.

23 (4) Summerfield, Florida Marion County, Out-
24 patient Clinic, $1,230,000.

25 (5) Knoxville, Tennessee, Outpatient Clinic,
26 $850,000.

1 (6) Toledo, Ohio, Outpatient Clinic,
2 $1,200,000.
3 (7) Crown Point, Indiana, Outpatient Clinic,
4 $850,000.
5 (8) Fort Worth, Texas, Tarrant County Out-
6 patient Clinic, $3,900,000.
7 (9) Plano, Texas, Collin County Outpatient
8 Clinic, $3,300,000.
9 (10) San Antonio, Texas, Northeast Central
10 Bexar County Outpatient Clinic, $1,400,000.
11 (11) Corpus Christi, Texas, Outpatient Clinic,
12 $1,200,000.
13 (12) Harlington, Texas, Outpatient Clinic,
14 $650,000.
15 (13) Waco/Marlin, Texas, Outpatient Clinic,
16 $2,600,000.
17 (14) Denver, Colorado, Health Administration
18 Center, $1,950,000.
19 (15) Oakland, California, Outpatient Clinic,
20 $1,700,000.
21 (16) San Diego, California, North County Out-
22 patient Clinic, $1,300,000.
23 (17) San Diego, California, South County, Out-
24 patient Clinic, $1,100,000.

1 (b) AUTHORIZATION OF APPROPRIATIONS.—There is
2 authorized to be appropriated to the Secretary of Veterans
3 Affairs for fiscal year 2005 for the Medical Care account,
4 $27,020,000 for the leases authorized in subsection (a).
5 (c) AUTHORITY FOR LEASE OF CERTAIN LANDS OF
6 UNIVERSITY OF COLORADO.—Notwithstanding section
7 8103 of title 38, United States Code, the Secretary of Vet-
8 erans Affairs may enter into a lease for real property lo-
9 cated at the Fitzsimons Campus of the University of Colo-
10 rado for a period up to 75 years.

11 **SEC. 3. DEPARTMENT OF VETERANS AFFAIRS CAPITAL**
12 **ASSET FUND.**

13 (a) ESTABLISHMENT OF FUND.—(1) Subchapter I of
14 chapter 81 is amended by adding at the end the following
15 new section:

16 **"§ 8117. Authority for transfer of real property; Cap-**
17 **ital Asset Fund**

18 "(a)(1) The Secretary may transfer real property
19 under the jurisdiction or control of the Secretary (includ-
20 ing structures and equipment associated therewith) to an-
21 other department or agency of the United States or to a
22 State (or a political subdivision of a State) or to any public
23 or private entity, including an Indian tribe. Such a trans-
24 fer may only be made if the Secretary receives compensa-
25 tion of not less than the fair market value of the property,

1 except that no compensation is required, or compensation
2 at less than fair market value may be accepted, in the
3 case of a transfer to a grant and per diem provider (as
4 defined in section 2002 of this title). When a transfer is
5 made to a grant and per diem provider for less than fair
6 market value, the Secretary shall require in the terms of
7 the conveyance that if the property transferred is used for
8 any purpose other than a purpose under chapter 20 of
9 this title, all right, title, and interest to the property shall
10 revert to the United States.

11 "(2) The Secretary may exercise the authority pro-
12 vided by this section notwithstanding sections 521, 522
13 and 541–545 of title 40 and section 501 of the McKinney-
14 Vento Homeless Assistance Act (42 U.S.C. 11411). Any
15 such transfer shall be in accordance with this section and
16 section 8122 of this title.

17 "(3) The authority provided by this section may not
18 be used in a case to which section 8164 of this title ap-
19 plies.

20 "(4) The authority of the Secretary under paragraph
21 (1) expires on the date that is seven years after the date
22 of the enactment of this section.

23 "(b)(1) There is established in the Treasury of the
24 United States a revolving fund to be known as the Depart-
25 ment of Veterans Affairs Capital Asset Fund (hereinafter

1 in this section referred to as the 'Fund'). Amounts in the
2 Fund shall remain available until expended.
3 "(2) Proceeds from the transfer of real property
4 under this section shall be deposited into the Fund.
5 "(3) To the extent provided in advance in appropria-
6 tions Acts, amounts in the Fund may be expended for the
7 following purposes:
8 "(A) First, for the costs associated with the
9 transfer of real property under this section, includ-
10 ing costs of demolition, environmental clean-up,
11 maintenance and repair, improvements to facilitate
12 the transfer and administrative expenses.
13 "(B) Second, if amounts remain after expenses
14 covered by subparagraph (A) are met, for the pur-
15 poses stated in subparagraph (A) for future transfer
16 of assets.
17 "(C) Third, if amounts remain for expenses
18 covered by subparagraphs (A) and (B) are met, for
19 historic preservation of any structure or other prop-
20 erty under the jurisdiction of the Secretary that is
21 listed on the National Register of Historic Places or
22 to which section 106 or 111 of the National Historic
23 Preservation Act applies.
24 "(c) The Secretary shall include in the budget jus-
25 tification materials submitted to Congress for any fiscal

1 year in support of the President's budget for that year
2 for the Department the following:
3 "(1) Specification of the real property transfers
4 to be undertaken in accordance with this section
5 during that fiscal year.
6 "(2) Specification of all transfers completed
7 under this section during the preceding fiscal year
8 and completed and scheduled to be completed during
9 the year during which the budget is submitted.
10 "(3) Specification of the deposits into, and ex-
11 penditures from, the Fund that are incurred or pro-
12 jected for each of the preceding fiscal year, the cur-
13 rent fiscal year, and the fiscal year covered by the
14 budget.".
15 (2) The table of sections at the beginning of such
16 chapter is amended by inserting after the item relating
17 to section 8116 the following new item:

"8117. Authority for transfer of real property; Capital Asset Fund.".

18 (b) INITIAL AUTHORIZATION OF APPROPRIATIONS.—
19 There is authorized to be appropriated to the Department
20 of Veterans Affairs Capital Asset Fund established under
21 section 8117 of title 38, United States Code (as added
22 by subsection (a)), the amount of $10,000,000.
23 (c) TERMINATION OF NURSING HOME REVOLVING
24 FUND.—(1) Section 8116 is repealed.

1 (2) The table of sections at the beginning of chapter
2 81 is amended by striking the item relating to section
3 8116.

4 (d) TRANSFER OF UNOBLIGATED BALANCES TO CAP-
5 ITAL ASSET FUND.—Any unobligated balances in the
6 nursing home revolving under section 8116 of title 38,
7 United States Code, as of the date of the enactment of
8 this Act shall be deposited in the Department of Veterans
9 Affairs Capital Asset Fund established under section 8117
10 of title 38, United States Code (as added by subsection
11 (a)).

12 (e) PROCEDURES APPLICABLE TO TRANSFERS.—(1)
13 Paragraph (2) of section 8122(a) is amended to read as
14 follows:

15 "(2) Except as provided in paragraph (3), the Sec-
16 retary may not during any fiscal year transfer to any other
17 department or agency of the United States or to any other
18 entity real property that is owned by the United States
19 and administered by the Secretary unless the proposed
20 transfer is described in the budget submitted to Congress
21 pursuant to section 1105 of title 31 for that fiscal year.".

22 (2) Section 8122(d) is amended—

23 (A) by inserting "(1)" before "Real property";
24 and

1 (B) by adding at the end the following new
2 paragraph:
3 "(2) The Secretary may transfer real property under
4 this section, or under section 8117 or 8164 of this title,
5 only after—
6 "(A) placing a notice in the real estate section
7 of local newspapers and in the Federal Register of
8 the Secretary's intent to transfer that real property
9 (including land, structures, and equipment associ-
10 ated with the property);
11 "(B) holding a public hearing;
12 "(C) providing notice to the Administrator of
13 General Services;
14 "(D) waiting for 30 days to elapse during which
15 no other Federal agency has expressed an interest in
16 acquiring the property at fair market value; and
17 "(E) after such 30-day period has expired, noti-
18 fying the congressional veterans' affairs committees
19 of the Secretary's intention to dispose of the prop-
20 erty and 60 days have elapsed from the date of such
21 notice.".
22 (3) Section 8164(a) is amended by inserting "8117
23 or" after "rather than under section".

1 (4) Section 8165(a)(2) is amended by striking "nurs-
2 ing home revolving fund" and inserting "Capital Asset
3 Fund established under section 8117 of this title.".

4 (f) CONTINGENT EFFECTIVENESS.—The amend-
5 ments made by this section shall take effect at the end
6 of the 30-day period beginning on the date on which the
7 Secretary of Veterans Affairs certifies to Congress that
8 the Secretary is in compliance with subsection (b) of sec-
9 tion 1710B of title 38, United States Code. Such certifi-
10 cation shall demonstrate a plan for, and commitment to,
11 ongoing compliance with the requirements of that sub-
12 section.

13 (g) CONTINUING REPORTS.—Following a certifi-
14 cation under subsection (f), the Secretary shall submit to
15 Congress an update on that certification every six months
16 until the certification is included in the Department's an-
17 nual budget submission.

18 **SEC. 4. AUTHORITY TO USE PROJECT FUNDS TO CON-**
19 **STRUCT OR RELOCATE SURFACE PARKING**
20 **INCIDENTAL TO A CONSTRUCTION OR NON-**
21 **RECURRING MAINTENANCE PROJECT.**

22 Section 8109 is amended by adding at the end the
23 following new subsection:

24 "(j) Funds in a construction account or capital ac-
25 count that are available for a construction project or a

1 nonrecurring maintenance project may be used for the
2 construction or relocation of a surface parking lot inci-
3 dental to that project.".

4 **SEC. 5. INAPPLICABILITY OF LIMITATION ON USE OF AD-**
5 **VANCE PLANNING FUNDS TO AUTHORIZED**
6 **MAJOR MEDICAL FACILITY PROJECTS.**

7 Section 8104 is amended by adding at the end the
8 following new subsection:

9 "(g) The limitation in subsection (f) does not apply
10 to a project for which funds have been authorized by law
11 in accordance with subsection (a)(2).".

12 **SEC. 6. IMPROVEMENT IN ENHANCED-USE LEASE AUTHORI-**
13 **TIES.**

14 Section 8166(a) is amended by inserting "land use,"
15 in the second sentence after "relating to".

16 **SEC. 7. EXTENSION OF AUTHORITY TO PROVIDE CARE**
17 **UNDER LONG-TERM CARE PILOT PROGRAMS.**

18 Subsection (h) of section 102 of the Veterans Millen-
19 nium Health Care and Benefits Act (38 U.S.C. 1710B
20 note) is amended—

21 (1) by inserting "(1)" before "The authority
22 of"; and

23 (2) by adding at the end the following new
24 paragraph:

1 "(2) In the case of a veteran who is participating in
2 a pilot program under this section as of the end of the
3 three-year period applicable to that pilot program under
4 paragraph (1), the Secretary may continue to provide to
5 that veteran any of the services that could be provided
6 under the pilot program. The authority to provide services
7 to any veteran under the preceding sentence applies dur-
8 ing the period beginning on the date specified in para-
9 graph (1) with respect to that pilot program and ending
10 on on December 31, 2005. ".

Statement of
The Honorable Anthony J. Principi
Secretary of Veterans Affairs
Before The
Subcommittee on Health
Committee on Veterans' Affairs
United States House of Representatives

June 24, 2004

Mr. Chairman and Members of the Subcommittee:

Thank you for providing the Department of Veterans Affairs (VA) this opportunity to discuss my recent decisions surrounding the Capital Asset Realignment for Enhanced Services (CARES) and the draft of a proposed bill to be entitled, "The Department of Veterans Affairs Real Property and Facilities Improvement Act of 2004." The bill contains several provisions that would significantly enhance VA's ability to manage and expand its capital resources while promoting efficiencies, and cost savings. Most importantly, the bill would facilitate the implementation of CARES. I request an opportunity to more closely review the specific provisions of the bill and supply the results of our review for the record.

As you know, last month I announced my decision on the future of VHA's capital infrastructure and publicly released my CARES Decision Document, copies of which have been provided to the Committee. It is not my intention today to discuss the details of the entire decision document. Instead, I will focus my discussion on the following issues of particular interest to the Committee:

1. The CARES Implementation Board;
2. Community Based Outpatient Clinics;

3. Mental Health Strategic Plan;
4. Long-term Care Strategic Plan;
5. Veterans Rural Access Hospital;
6. Special Disability Program for Spinal Cord Injury and Disorders;
7. Capital Initiatives for the Veterans Health Administration; and
8. VA/DoD Sharing Opportunities

Before I address those topics, however, I would like to provide a brief background on CARES.

Background

CARES is a data-driven planning process designed to project future demand for health care services, compare projected demand against current supply, and identify the capital requirements and asset realignments VA needs to meet future demand for services, improve access to and quality of services, and improve the cost effectiveness of VA's health-care system. The CARES process is a comprehensive, system-wide approach to projecting into the future the appropriate function, size and location of VA facilities. CARES was initiated to provide a plan for management of VA's capital infrastructure into the future that can be improved over time. For that reason, the tools and a process used to develop CARES will be integrated into annual capital and strategic planning cycles, ensuring continued and systematic planning for the capital resources VA needs to provide quality health care to veterans.

On February 12 of this year, the CARES Commission presented its final report to me. Following an intensive review of this report, I issued my "CARES Decision" on May 7, 2004. In that decision, I formally accepted the CARES Commission's recommendations using the flexibility the Commission provided to minimize the effect of any campus or service realignment on continuity of care to veterans currently receiving services. My Decision and the CARES Commission Report form the blueprint that will effectively guide the Department as it moves

forward to enhance and improve health-care delivery to veterans by modernizing and more effectively managing its capital infrastructure.

CARES Implementation Board

To oversee the many and varied actions needed to carry out my CARES Decision, I established the CARES Implementation Board, which I will personally chair. The Board will provide Departmental oversight of CARES implementation and advise me on CARES-related decisions. The Board is an intra-Departmental, senior-level group and will ensure that implementation actions are consistent with my CARES Decision, meet the Decision's aggressive timeframes, and honor the personal and public commitments made during the CARES process.

The Board will actively participate in developing the methodologies and structure of CARES reviews and studies as called for in my Decision. All CARES decisions will be presented to the Board for my approval, unless approved by me for delegation. Recently the Board held its first meeting and reviewed options regarding the composition and membership of committees, task forces and other groups that will be established to conduct the various studies outlined in my CARES Decision. I expect that guidance will be finalized for my approval in the near future so that these groups may begin their studies and reviews.

Community-Based Outpatient Clinics (CBOCs)

VA is committed to continuing its efforts to meet national standards for access to care for our Nation's veterans by establishing new sites of care through CBOCs. VA will also continue to explore opportunities to improve management of existing CBOCs through more effective staffing, expanding hours of operation, and examining opportunities to augment services where appropriate.

To ensure that VA fulfills its commitment, I established priority criteria for the development of new CBOCs through the CARES process. The priority criteria include the development of CBOCs that:

1. are in markets with large numbers of enrollees, are outside of access guidelines, and are below VA national standards for primary care access;
2. are in markets that are classified as rural or highly rural and are below VA national standards for primary care access;
3. take advantage of VA/DoD sharing opportunities;
4. are associated with the realignment of a major facility; and
5. are required to address the workload in existing overcrowded facilities.

These criteria reflect my determination to produce more equitable access to VA services across the country, particularly in rural and highly rural areas where there are often limited health care options. They also reflect VA's ongoing commitment to strengthening sharing opportunities with the Department of Defense.

My Decision identifies 156 priority CBOCs. These priority CBOCs are targeted for implementation by 2012 pending availability of resources, validation with the most current data available, and approval through the National CBOC Approval Process and the CARES Implementation Board. As VA proceeds in implementing CARES and engages in future planning, the locations of these CBOCs may change, but the priorities will remain constant.

Planning the implementation of new CBOCs has begun. On May 13, 2004, a revised VA Handbook on Planning and Activation of CBOCs was issued to all VISNs. At the same time, VISNs were provided guidance on submission of new CBOC business plans. VISNs are now in the process of preparing business plans for priority CBOCs identified in my Decision that are planned for activation in FY 2004. Additionally, VISNs are preparing business plans for priority CBOCs planned for FY 2005 that require immediate review in order to proceed with

VA/DoD agreements and leasing or contracting obligations. These business plans are to be completed and submitted to the Acting Under Secretary for Health by the end of this month. A review panel will evaluate the business plans, score the applications and develop a recommendation that the Acting Under Secretary for Health will submit to me for approval.

VISNs also received guidance regarding establishing outreach clinics to an existing primary care site, changing the location of an existing CBOC, leasing additional space for an existing CBOC, expanding services at an existing CBOC and changing management models at CBOCs, such as VA-staffed or contract. To obtain approval for any of these changes to CBOCs, the VISNs must submit a justification for the change and a summary of stakeholder comments. In the case of establishing an outreach clinic subordinate to an existing primary care site, approval will be granted only for areas that meet the distance criteria for highly rural areas specified in the national planning criteria.

I should point out that although I established priority criteria and identified 156 priority CBOCs that meet these criteria, these priorities do not prohibit the VISNs from pursuing other CBOC opportunities. VISNs may submit business plans for establishing CBOCs earlier than originally indicated in my Decision or for establishing CBOCs not referenced in my Decision. In either scenario, however, the VISN must demonstrate that it will, at the same time, be able to open any priority CBOC on schedule.

Mr. Chairman, I recognize that resources are not available to open all of the priority clinics immediately. I will work closely with Congress for approval of appropriations to enhance access to VA health care services as well as expand the types of services offered in outpatient sites, particularly specialty care such as mental health services. Moreover, VA will manage implementation of CBOCs by applying the revised CBOC criteria within the existing National CBOC Approval Process and through the authority of the CARES Implementation

Board. This will ensure a careful and considered implementation that mandates VISNs develop sound business plans and ensures that national criteria are met and that resources are available to provide the high quality of care veterans expect from VA.

Mental Health Strategic Plan

VA is committed to meeting the mental health needs of our Nation's veterans, and it is critical that VA's health care system consistently provides comprehensive mental health care services at a high level of quality across the country. Effective mental health treatment requires that veterans have appropriate access to a full continuum of mental health care services.

In my Decision I called for a comprehensive VA Mental Health Strategic Plan. This strategic plan, which is nearing completion, incorporates the recommendations of the report of the President's New Freedom Commission on Transforming Mental Health Care in America through VA's Action Agenda for Transforming Mental Health Care in VA. The recommendations resulting from the VA Mental Health Strategic Plan will require every VISN to develop mental health market plans that incorporate revised projections, which must include projected demand for outpatient mental health services and acute psychiatric inpatient care. Additionally, policies developed in the Mental Health Strategic Plan, such as special emphasis on integrating strategies to meet the future geropsych needs of the enrolled veteran population and incorporating the findings VHA's Work Group reviewing the President's New Freedom Commission on Mental Health Report, will be incorporated in the VISN's plans to ensure that comprehensive mental health services are included in CBOCs; that veterans have access to a full continuum of mental health care services, which are consistent across all VISNs; and ensure acute inpatient mental health services are collated with other inpatient services. I expect to receive the Mental Health Strategic Plan later this summer.

Long-term Care Strategic Plan

Mr. Chairman, many stakeholders have expressed concerns about how VA intends to address the provision of long-term care within the context of CARES. In order to respond to these concerns, I directed in my Decision that VHA develop a Long-term Care Strategic Plan addressing

- consistent access for nursing home care;
- geropsych needs;
- domiciliary care;
- long-term psychiatric care for the seriously mentally ill;
- expanding care coordination in the home;
- residential care, assisted living facilities; and
- other less restrictive care settings.

I am currently considering various policy options that have been designed to adhere to certain core principles, which include a policy that is clinically sound, is fair for veterans, can be modeled for VISN planning, and is acceptable to Congress. Some of the key elements that I will strongly consider are the extent to which the Long-term Care Strategic Plan:

- focuses on veterans who need care for a short duration, for services to restore function following a period of hospitalization, for example, patients who have had a heart attack, stroke or hip replacement; veterans in need of respite care, and geriatric evaluation and management to stabilize medically complex patients; or end-of-life, hospice and palliative care for those who are terminally ill; and
- focuses on veterans who can no longer be maintained safely in home and community-based settings such as elderly patients needing help with activities of daily living, or who require long-term maintenance care and specialized services not generally available in the community, such as chronically mentally ill patients, spinal cord injury or traumatic brain injury patients, and ventilator dependent patients.

The Long-term Care Strategic Plan will be designed to improve the veteran's quality of life by seeking to preserve personal dignity, enhance emotional well being, and provide care in the least restrictive setting possible.

In addition to long-term nursing home care, VA is reviewing its long term-care policy in other key program areas, such as domiciliary and residential rehabilitation programs. VA's long-term care policies relating to these programs will assure that programs in domiciliary structures are focused on residential rehabilitation and that each patient has a clinical treatment plan. As each program (*e.g.,* mental health, substance abuse, and long-term care) defines its discrete capacity for residential rehabilitation, VA will have a more complete picture of the total capacity requirement for domiciliaries.

I will, of course, keep Congress informed of the Long-term Care Strategic Plan once adopted. Once again, in all cases, the Long-term Care Strategic Plan will be designed to improve the veteran's quality of life by seeking to preserve personal dignity, enhance emotional well being, and provide care in the least restrictive setting possible.

Veterans Rural Access Hospital

VA is also reviewing the "critical access hospital" concept that was initially introduced to help ensure the quality of the care that veterans receive at VA's small facilities. Recognizing that some small and rural facilities will be unable to maintain the workload necessary to perform certain surgical procedures or manage some complex illnesses effectively, VA will establish parameters to ensure high quality patient care. A new policy, Veterans Rural Access Hospital (VRAH), is under development and will specifically define the clinical and operational characteristics of small and rural facilities within VA. I have directed that the VRAH policy be completed later this month. In the interim, the missions of small facilities recommended for change will not be altered. Once the new VRAH policy is approved, however, VA will study the scope of services

performed at VA's small and rural facilities using the policy's criteria and the guidance that will be provided. I anticipate the outcome of this study will be clarification of the type and complexity of surgical procedures that can be safely accomplished in small and rural facilities.

Special Disability Program for Spinal Cord Injury and Disorders (SCI&D)

I recommitted VA to excellence in care for veterans with SCI&D by approving new SCI&D Centers in Syracuse, Denver, Minneapolis, and VISN 16, and a certified SCI&D outpatient clinic in Philadelphia. I also approved expansion of existing SCI&D Centers in Memphis, Cleveland, Augusta, and Long Beach. As part of the implementation process for the new centers and the expansion of existing centers, I requested that VHA validate the number of SCI&D beds to ensure the appropriate need for and distribution between acute and long-term SCI&D beds. I also requested that VHA validate the expansion of the existing SCI&D Center or development of a new SCI&D Center in South Florida.

In preparation for implementation of the new and expanded SCI&D Centers, members of VHA's SCI&D Strategic Health Care Group have reviewed and validated SCI&D beds. A balance has been achieved between acute and long-term care planning based on dual, actuarial, demand-forecasting models that have been peer-reviewed, scrutinized, and vetted. The "*CARES Major Construction Projects FY 2004-2010*" appropriately includes plans for expansion of the existing SCI&D Center in Tampa. The new VISN 16 SCI&D Center needs inclusion in the "*CARES Major Construction Projects FY 2004-2010*". Ongoing planning for long-term care outside the SCI&D Centers will be refined after publication of VA's Long-Term Care Strategic Plan.

Capital Initiatives

I am pleased to announce that VA has developed a long-term Capital Plan, which will be delivered to members of Congress shortly. With more than

5,500 buildings and approximately 32,000 acres of land nation-wide, it is critical that VA have a systematic and comprehensive framework for managing its portfolio of capital assets. This plan provides that framework and is a sound blueprint for effective management of the Department's capital investments that will lead to improved resource use and more effective health care and benefits delivery for our Nation's veterans.

As we strive to meet the many challenges that lie ahead, this plan will act as our guide. I recently announced my decisions on the Capital Asset Realignment for Enhanced Services (CARES) process. CARES is the most comprehensive analysis of VA's health-care infrastructure that has ever been conducted and my decision provides a 20-year blueprint for the critical modernization and realignment of VA's health care system. Consistent with my decision, the capital plan outlines CARES implementation and identifies priority projects that will improve both the environment of care at, and expand access to, VA medical facilities and ensure more effective operations by redirecting resources from maintenance of vacant and underused buildings and reinvesting them in veterans' health care. Implementation of CARES will require substantial investment. While I will assess what amounts should be funded in future budgets, this plan reflects a need for additional investments of approximately $1 billion per year for the next 5 years to modernize VA's medical infrastructure and enhance veterans' access to care.

The capital plan also identifies our highest priority needs for new construction and expansion of cemeteries in areas where burial sites will soon be depleted, new benefits administration office facilities, and information technology projects designed to improve customer service and enhance delivery of VA benefits.

Additionally, this plan describes how VA will enhance collaborative efforts with the Department of Defense and increase the use of public and private

ventures through VA's enhanced-use lease authority. By improving the way that we manage the enhanced-use lease process and engaging in productive public and private partnerships, VA can enhance benefits and services to our Nation's veterans and more effectively fulfill our mission.

As we move forward, VA will continue to improve stewardship of the funds entrusted to us by more effectively managing our capital assets and planning to meet the future needs of America's veterans and their families. By employing best business practices and maximizing the functional and financial value of our capital assets through well thought-out acquisitions, allocations, operations, and dispositions, VA will continue to ensure that all capital investments are based on sound business principles and -- most importantly -- meet our veterans' health care, benefits, and burial needs. I am confident that effective implementation of this plan will help us to achieve these important results.

VA's capital investment planning process and methodology ensure a Department-wide approach for the use of capital funds and ensure all major investments are based upon sound economic principles and are fully linked to strategic planning, budget, and performance measures and targets. On May 20, 2004, I transmitted an interim report to VA's 5-Year Capital Plan entitled "CARES Major Construction Projects Fiscal Year (FY) 2004 – 2010" to Congress. This interim report includes VA's highest priority major medical facility construction requirements over the next five years. VA's comprehensive 5-year capital plan will include other specific capital requirements such as leasing, minor construction, and community based outpatient clinics.

The projects listed in the interim report were identified through the CARES planning process as well as the VA's capital investment process, and support decisions identified in my CARES Decision. The CARES process focused on capital requirements at a macro-level by using projections of beds and inpatient and outpatient services. Once performance gaps were identified in the market

plans, business case applications were developed for specific major construction projects in order to fill these gaps. Business case applications were scored and prioritized based on how well they addressed each of the criteria in the capital decision model. Over 100 CARES concept papers and business case applications were submitted and reviewed through VA's capital investment process utilizing criteria I approved in May 2004.

Once Congress approves the FY 2005 appropriations, VA will have more than $1 billion available to begin renovating and modernizing VA's health care system. In the next six months, VA intends to make 28 design awards, one land purchase, and a construction award for a bed tower at the West Side VA Medical Center in Chicago, Illinois. VA will use available funds from FY 2004 and prior year appropriations and funds appropriated for FY 2005 to carry out these awards. VA will proceed with planning and construction once the requirements of section 221 of Public Law 108-170 are fulfilled, which allows me to carry out major construction projections specified in the final CARES report 45 days after my submission of the interim report that was delivered to Congress on May 20th of this year.

VA/DoD Sharing Opportunities

Sharing between the Department of Veterans Affairs and the Department of Defense is a priority of the President and for both Departments. As my CARES decisions are implemented, we will continue to take all necessary steps to identify and act on available sharing opportunities.

My CARES decision identified 35 promising sharing opportunities. Working through the VA/DoD Joint Executive Council (JEC), co-chaired by VA's Deputy Secretary and DoD's Under Secretary for Personnel and Readiness, VA and DoD have already begun to work more closely toward making a reality of many of these opportunities.

For example, my CARES Decision, as well as VA's 5-Year Capital Plan, includes a number of significant ventures for VA – DoD collaboration including two new federal medical facilities in Denver, Colorado and Las Vegas, Nevada, a joint outpatient clinic in Pensacola, Florida, an outpatient clinic and regional office in Anchorage, Alaska, and an outpatient clinic in Columbus, Ohio.

In addition, the JEC recently established a Capital Asset Planning and Coordination Steering Committee, which will be responsible for identifying and overseeing opportunities that maximize capital asset resource utilization for both Departments. This body will oversee implementation of the VA/DoD recommendations that require capital planning and will seek to maximize productive collaboration between Departments in developing capital asset management sharing opportunities in the future. Both Departments recognize the importance of capital coordination efforts at the local level and the Capital Asset Planning and Coordination Steering Committee is working to improve the stability of VA/DoD partnerships through transition of management at local facilities.

With my discussion of the Department's capital initiatives and VA/DOD Sharing Opportunities as a backdrop, I will now turn to Section 2 of the proposed bill.

Section 2. Capital Leases

Section 2 would authorize me to enter into contracts for leases for the following seventeen facilities:

(1) Wilmington, North Carolina, Outpatient Clinic, $1,320,000;

(2) Greenville, North Carolina, Outpatient Clinic, $1,220,000;

(3) Norfolk, Virginia, Outpatient Clinic, $1,250,000;

(4) Summerfield, Florida Marion County, Outpatient, Clinic, $1,230,000;

(5) Knoxville, Tennessee, Outpatient Clinic, $850,000;

(6) Toledo, Ohio, Outpatient, Clinic, $1,200,000;

(7) Crown Point, Indiana, Outpatient Clinic, $850,000;

(8) Fort Worth, Texas, Tarrant County Outpatient Clinic, $3,900,000;

(9) Plano, Texas, Collin County Outpatient Clinic, $3,300,000;

(10) Saint Antonio, Texas, Northeast Central Bexar County Outpatient Clinic, $1,400,000;

(11) Corpus Christi, Texas, Outpatient Clinic, $1,200,000;

(12) Harlingen, Texas, Outpatient Clinic, $650,000;

(13) Waco/Marlin, Texas, Outpatient Clinic, $2,600,000;

(14) Denver, Colorado, Health Administration Center, $1,950,000;

(15) Oakland, California, Outpatient Clinic, $1,700,000;

(16) San Diego, California, North County Outpatient Clinic, $1,300,000; and

(17) San Diego, California, South County, Outpatient Clinic, $1,100,000.

Of these 17 leases, the leases in Norfolk, Virginia; Summerfield, Florida; Plano, Texas and San Antonio, Texas are new. The remaining 13 leases are replacement or expansions for existing leases. Please note that the leases in Section 2 should be identified as operating leases because they do not meet the required characteristics of a "capital lease". Capital leases are subject to specific requirements such as being scored under the OMB scorekeeping rules and the requirement that the entire cost of the lease be expended during the first year of the lease.

Section 2 of the bill authorizes for appropriation the sum of $27,020,000 for fiscal year 2005 for the Medical Care account for the leases listed in this section. My comment on the total amount of the authorization is consistent with my previous comments regarding the authorization of the seventeen leases identified in this section.

Section 2 further authorizes me to enter into a lease for real property located at the Fitzsimons campus of the University of Colorado for a period of up to 75 years. We have been involved in evaluating and planning for a facility for the Fitzsimons site and there is a potential for a joint venture with DOD to provide health care to both veterans and DOD beneficiaries. Of the many issues remaining, the availability of land is a critical one.

The bill provides the Department a new leasing authority. The bill permits the VA to enter into a long-term lease of up to 75 years at the University of Colorado Hospital at the Fitzsimons Campus of the University of Colorado. This authority is necessary for the VA to acquire a sufficient land interest for the construction of a new medical facility on the Fitzsimons Campus. We support this proposal. The VA will enter into a sharing agreement with the University of Colorado Hospital, which will produce economies of scale of benefit to both parties. It is anticipated that this facility will be a joint operation of the Department of Veterans Affairs and the Department of the Air Force.

Section 3. Department of Veterans Affairs Capital Asset Fund

Section 3 of the bill would authorize VA to dispose of its excess real property by transfer to a Federal agency, a state or political subdivision of a state or to any public or private entity and to retain the proceeds generated by the disposals. We support this provision except for the language that limits the authority to the transfer of real property. To prevent any misinterpretation, we recommend that the words "sale, exchange, and" be inserted before the word transfer. This language will allow us to implement the nationwide recommendations of the recent CARES decision in a timely and efficient manner. Further, the section provides that VA receive compensation of not less than the fair market value of the property except in the case of a transfer to a grant and per diem provider (as defined in section 2002 of title 38). Further, the property

would revert to the United States if the property transferred to a grant or per diem provider is used for other purposes. This latter provision could have government-wide implications, so until a thorough vetting of this provision is completed, we are not prepared to opine on it at this time.

The authority may be exercised notwithstanding 40 U.S.C. §§ 521, 522 and 541-545 and the McKinney-Vento Homeless Assistance Act (which provides that unused or underutilized Federal real property may be used to assist the homeless). We support this provision only because VA's homeless assistance programs now constitute the largest integrated network of services in the U.S.. In 2005 VA will spend $1.5 billion on medical services for the homeless and another $188 million on programs to return homeless veterans to stable living. These programs include outreach, case management, transitional residential care, rehabilitation care, income support assistance, permanent housing assistance, and follow-up care. We continually ensure that our property policies address the needs of the homeless. Section 3 of the proposed bill further provides that any such transfer shall be in accordance with this section and section 8122 of title 38. Section 8122 of title 38, requires that VA report the proposed transfer in its annual budget document before transferring real property valued in excess of $50,000 to another Federal agency or to a state or a political subdivision of a state for fair market value. As most parcels of real property exceed the $50,000 threshold, this would require VA to submit disposal information each time it sought to transfer real property to another Federal agency or to a state or a political subdivision. Therefore, we object to this provision. We suggest the proposal be amended to require the submission of a report along with the budget request for property valued equal to or more than the Major Medical Facility Project threshold identified in subsection 8104(a)(3)(A) of title 38.

The bill further provides that the authority provided by this section may not be used in a case in which section 8164 of title 38 (enhanced use) applies. We

support this provision. The exercise of this authority expires seven years after the date of the enactment of this section. We strongly object to this provision. Should a 7-year limitation be established, we recommend that the Secretary transfer to any account or accounts any unobligated and undistributed dollars remaining in the Fund upon expiration of the authority. The proceeds from the transfer of real property under this section would be deposited in a Capital Asset Fund (the "Fund"), as provided for by this legislation. The bill would also terminate the Nursing Home Revolving Fund and deposit funds therein into the Fund. Further, the bill would authorize to be appropriated to the Fund $10,000,000.

Amounts in the Fund would have to be used for the costs of actual or planned disposals of real estate, including demolition, environmental cleanup, improvements to facilitate the transfers and administrative expenses. If amounts remain after those expenditures, like expenditures may be made for future transfers. Any remaining amounts are to be used for historic preservation as set forth in legislation. We appreciate the provisions that establish use of the Fund. However, we object to the limitation on the use of the proceeds to historic preservation after expenses. We would strongly support use of the Fund for non-recurring VA Capital projects as well as historic preservation.

Property may only be transferred under this section, or under sections 8117 or 8164 of title 38, after: (a) placing notice of my intent to do so in the local newspapers and in the Federal Register; (b) holding a public hearing; providing notice to the Administrator of General Services; (c) waiting 30 days to determine if another Federal agency has an interest in acquiring the property at fair market value; and (d) thereafter, providing a 60-day notice period for the congressional veterans' affairs committees to review the intended property disposal. We support the report and wait requirement of this section as it relates to 8117, but object to its application to 8164. The basis for the objection is that section 8164 already has specific notification requirements.

Section 3, additionally, would make two conforming amendments to VA's enhanced-use lease statute. First, it would amend section 8164(a) to provide that, before disposing of an enhanced-use leased property pursuant to section 8164, I must determine that a disposal under that section, rather than under the proposed new section 8117 (or under section 8122), would be in the best interests of the Department. Next, it would amend section 8165 (a)(2) to provide that proceeds from a disposal of enhanced-use leased property would be deposited in the proposed new Capital Asset Fund, vice the Nursing Home Revolving Fund.

Further, Section 3 states that the amendments made therein shall take effect at the end of the 30-day period beginning on the date that I certify to Congress that I am in compliance with subsection (b) of section 1710B of title 38. Also, following this certification, I am required to submit an update to Congress on that certification every six months until the certification is included in the Department's annual budget submission. The ability to better manage our capital assets through this section's real property disposal authority and compliance with 1710B(b) of title 38 are not appropriately joined. Conditions that may influence the Department's ability to meet its capacity requirements may not always be within our control. Therefore, VA objects to this provision.

Section 4. Authority to use Project Funds to Construct or Relocate Surface Parking Incidental to a Construction or Non-Recurring Maintenance Project

Section 4 of the bill would add language to Section 8109 that would allow funds in a construction account or capital account that are available for a construction project or nonrecurring maintenance project to also be used for constructing or relocating a surface parking lot incidental to that project. VA supports this provision of the bill.

Section 5. Advance Planning Funding for Major Medical Facilities

This bill would also exempt projects that have already been authorized by law from current statutory notice and wait requirements that apply to certain major medical facility projects. VA supports this provision of the bill.

Section 6. Improvement in Enhanced-Use Lease Authorities

This section would amend section 8166(a) to clarify that, in addition to the bar against subjecting any construction, alteration, repair, remodeling, or improvement of enhanced-use leased property to any State or local law relating to building codes, permits or inspections, such activities are to be exempt from any State or local law relating to land use, unless I provide otherwise. We support this provision.

Section 7. Extension of Authority to Provide Care Under Long-Term Care Pilot Programs

Section 7 of the draft bill would authorize VA to continue furnishing certain long-term care services to a very limited group of veterans still participating in a long-term care pilot program, the authority for which will be expiring soon. VA supports section 7 of the bill.

The Veterans Millennium Health Care and Benefits Act, enacted in 1999, directed that VA carry out a relatively small three-year pilot program to furnish veterans with all-inclusive long-term care services using three different models of care delivery. The effort was intended to test the feasibility, acceptability, outcomes and costs of care using each model. VA patterned the pilot on the Medicare Program of All-Inclusive Care for the Elderly, commonly referred to as the PACE Program. VA conducted the pilot program in three separate locations. In Dayton, Ohio, VA directly furnished pilot participants with all of the services typically included in the PACE Program. In Denver, VA furnished some of the services directly, but paid a capitated amount to a private Colorado PACE provider to furnish the remainder of the services. Finally, in Columbia, South

Carolina, VA served as the care manager, but a private PACE provider furnished all care, receiving a capitated amount from VA. The authority for the pilot program will be expiring later this year, and VA will be reporting to Congress regarding the program in March of 2005, as required by law.

At this point in time, the pilot program is winding down. VA has not been enrolling any new veterans in the pilot for some time. However, a few veterans will still be receiving care under the program when it ends. To ensure continuity of care and avoid disruption in the life of these elderly and frail patients, section 7 would authorize VA to continue to furnish these few veterans with the same services they have been receiving, in the same settings, until December 31, 2005. That time period would allow Congress time to review the post-pilot report, including VA's recommendations, and decide how to proceed. VA also anticipates that by that time, most participants will have moved to a different care setting.

Conclusion

Mr. Chairman, my CARES Decision and accompanying 5-year Capital Plan represent a blueprint for VA's future. Sophisticated forecasting models provide new and more complete information about the demand for VA health care. A comprehensive assessment of VA's facilities has greatly improved our understanding about the condition of VA's facilities. These factors, combined with the experience of conducting the CARES process, leave the Department well positioned to continue to expand the accuracy and scope of its planning efforts. Throughout the CARES implementation process we will keep you and other members of Congress informed and involved and, just as important, we will keep our patients and their families informed and involved.

This concludes my statement. I will now be happy to answer any questions that you or other members of the Subcommittee might have.

STATEMENT OF
THE HONORABLE EVERETT ALVAREZ, JR.
FORMER CHAIR OF THE VA CARES COMMISSION
BEFORE THE SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

June 24, 2004

Mr. Chairman and members of the Subcommittee, good morning.

I am pleased to be here today on behalf of the CARES Commission, to discuss the CARES Commission Report, which was presented to Secretary Principi on February 12, 2004.

I can attest that the Commissioners, individuals with broad experience in health care and veterans' advocacy, recognized the enormity and importance of their task: to critique and modify a blueprint for enhancing the health care of as many veterans as feasible into the future. Let me emphasize that point. The Commission viewed the Draft National CARES Plan as a blueprint for VA health care for the next 20 years.

Health care delivery in this country is changing. VA's health care delivery is under change and this change needs to be managed carefully and respectfully. The Commission sees this blueprint as a roadmap to the future -- a tool to help in managing future change.

The Commission, within time restraints, evaluated enormous amounts of data, listened to many veterans, providers of care, and stakeholders at 81 site visits and held 38 public hearings across the country, and focused our collective experience and reasonableness on the task.

Our report, which you have, is large and far-reaching. It included important discussions and recommendations on issues that cut across the entire VA health

care system. It also included hundreds of site-specific recommendations. If the plan is to succeed in its goals, priorities still need to be attended to and properly aligned; evaluations still need to be conducted for important components of VA health care; and, internal processes need to be overhauled.

I wish to share the key principles that served as a beacon to guide the Commission through our complex deliberations.

First and foremost: to improve access to as many veterans as possible to high quality, veteran-specific health care. Many VA facilities were largely built 40 or 50 years ago or more. Population demographics have shifted. The delivery of health care has increasingly become an issue of access, both for veterans and their families who need to partner in their care.

Cost efficiency. When, as is the case today, the health care needs of some veterans are unfulfilled, particularly for the highest priority veterans with war related physical and mental disabilities, then efficiency is also an issue of access and quality of care. If we do not use resources as efficiently as we can, some veterans in dire need of services may not receive the care they need or deserve. Therefore, the Commission also looked at the cost benefit of each recommendation. We recognized that the cost data provided were often in need of further refinement, forcing us to consider the likelihood, based on past experience in VHA and a test of reasonableness, that an action would improve efficiency.

The impact of change in the status quo on current recipients of service, current VA employees, and the communities where our facilities have been historically located was another key principle that guided the Commission. The Commission recognized that the shifting of resources necessary to improve overall access would be a hardship for some. We expect that the implementation of necessary change will take this into account when time-lines for modifications

are finalized.

The Commission's recommendations were our assessment of what is best for VA health care as VA moves forward. We are not infallible; we understand that things will change over time, and there may be factors that need to be reconsidered. However, this was our best effort.

I am pleased and gratified that the Commission's efforts provided Secretary Principi a roadmap to the future for VA health care. We look to Secretary Principi and to the Congress to further refine and improve upon our assessment, keeping, we hope, in their focus, the principles that have guided our deliberations to provide access to high quality health care to as many veterans as resources permit.

Mr. Chairman and members of the Subcommittee, I would like to thank you for the opportunity to address you. I would be pleased to respond to any questions you may have and to an ongoing dialogue we trust will move all of us closer to our jointly held goal to serve those who have and are serving our country.

Testimony of
Dennis C. Brimhall
President and CEO
University of Colorado Hospital
Presented to Committee on Veterans' Affairs
Subcommittee on Health
U.S. House of Representatives
June 24, 2004

Mr. Chairman and Distinguished Members of the Committee:

Thank you for the opportunity to discuss the collaborative efforts between the Department of Veterans Affairs (VA), the Department of Defense (DoD) and the University of Colorado Hospital (UCH) and University of Colorado Health Sciences Center (UCHSC) to build a Federal Health Care Tower at the new Fitzsimons Campus. There are unprecedented opportunities for these partners to join together on the campus of the former Fitzsimons Army Hospital. These opportunities include improving the quality of care for the citizens of Colorado, for our veterans and for the men and women in the armed services, including their families. There are also great opportunities to share and improve the efficiencies and reduce costs for all parties.

An Unprecedented Model of Collaboration and Cooperation

The U.S. Department of Veterans Affairs (VA), the University of Colorado Health Sciences Center (UCHSC) and University of Colorado Hospital have a very long and mutually beneficial relationship. It dates back to 1946 when, in order to meet the country's need for medical services for veterans at the end of World War II, new hospitals were planned, including one to be built in Colorado.

Representatives of the CU School of Medicine and other interested parties lobbied to have the new hospital built adjacent to the medical school on the campus at Ninth Avenue and Colorado Boulevard in Denver. They argued that this would have many advantages both to the VA and the

university. The VA would benefit from this affiliation in attracting the best physicians and gaining access to the research enterprise; the medical school would benefit by a quality partner and an increase in the number of teaching beds; and both entities would enjoy great savings from economy of scale.

The new VA hospital opened in 1951 next door to the School of Medicine. Within a few years, the clinical, teaching and research programs of the two entities were fully integrated.

This mutually beneficial relationship between the VA, University of Colorado Hospital and the Health Sciences Center, which began more than 50 years ago, was declared at the time to be "without precedent in the history of federal hospitalization."

I am here today to express our appreciation for the wonderful cooperation and collaboration that has marked this relationship from the beginning; and to talk with you about unique and even greater opportunities that are now before us to take this historic relationship in new directions that are again without precedent. This opportunity includes an additional quality partner, the United States Department of Defense (DoD).

The Need to Expand by the University of Colorado Health Sciences Center and the University of Colorado Hospital

By the mid 1990s, University of Colorado Hospital and UCHSC desperately needed to expand patient care, research and educational facilities. The 46-acre site at Ninth Avenue and Colorado Boulevard in Denver had reached maximum capacity.

At the same time, the Fitzsimons Army Medical Center in Aurora was listed on the Base Realignment and Closure list. The 577-acre site had been a medical military installation since 1918. When it was clear that the base was to be closed, officials from the University of Colorado Hospital, UCHSC and the City of Aurora proposed an innovative concept to the U.S. Department of Defense – to reuse the site to create a model health sciences city for the 21st century.

The concept was approved and 227 acres of the Fitzsimons site were conveyed from the DoD to the Department of Education to the university in 1995. UCHSC and University of Colorado

Hospital began planning to move all services and facilities to the new campus, which would be built from the ground up – an extraordinary opportunity.

Impact on the VA

The move of University of Colorado Hospital and the Health Sciences Center, although essential to their continued growth and successful future, posed problems for the VA. Physical separation would threaten the mutually beneficial relationship, which included integration of faculty, facilities, programs, patients, education and shared equipment.

The VA facility also was old and outdated. Additionally, after UCHSC and University of Colorado Hospital moved to the new medical campus at Fitzsimons, the relationships would continue, but the efficiency and effectiveness of future cooperation would be more difficult. VA representatives expressed interest in exploring a move to Fitzsimons as well. An initial study was undertaken in 2000 to determine if the opportunity merited further exploration and a second move study was done two years later. These studies concluded that the pending separation of the VA hospital from the UCHSC could be harmful, but that another even greater opportunity existed. This opportunity was to relocate the Denver Veterans Affairs Medical Center (DVAMC) to the Fitzsimons campus as well. The preferred option would enhance the sharing between entities; improve the quality of care, provide access to sophisticated medical care, and deliver savings in both capital expenditures and ongoing operational costs.

CARES Commission Ranks It Among Top Three

In February of this year, the Capitol Asset Realignment for Enhanced Services (CARES) Commission, which studied all VA medical facilities in the country, recommended that a replacement facility be built at Fitzsimons. It was one of only three new hospital projects in the country to be recommended and was ranked "high priority." Recently, Secretary Anthony Principi of the Department of Veterans Affairs, concurred with the CARES Commission report and approved the planning and design necessary for the DVMC move to the Fitzsimons campus. Congress has authorized planning and appropriated money for architectural work for the replacement medical facility.

Department of Defense Interest in Fitzsimons

While the Department of Veterans Affairs studied a move to Fitzsimons, the Department of Defense redesignated nearby Buckley as a full Air Force base in 2000, entitling it to a Military Treatment Facility (MTF). Rather than build the new hospital at Buckley, the DoD determined that it would be better to move to Fitzsimons where it could benefit from sharing facilities, physicians and services with University of Colorado Hospital, the Health Sciences Center and the VA.

In addition to new opportunities for economics of scale resulting from sharing, Air Force personnel would benefit from state-of-the-art medical care and there would be expanded services for TRICARE populations. Air Force medical personnel would have increased opportunities for training and experience in cardiovascular, neurological and other specialty skills with the resulting partnerships and increase in patients.

The Impact on the University of Colorado Hospital

The University of Colorado Hospital and the UCHSC have long valued their relationships with the VA and the DoD. The need to continue this relationship is important. The move to the Fitzsimons campus creates the opportunity to enhance the relationships and increase the sharing, thus reducing cost for all parties. The land at Fitzsimons is very precious and all uses of the land must be weighed against other potentially more valuable uses. Making land available to the VA and DoD on the Fitzsimons campus was subject to this "opportunity cost" analysis. The VA/DoD use of the land rises to the top because of the potential for capital and operations cost savings. These savings come from sharing. This sharing should be done only if it benefits all parties. It is UCH's expectation that having the DoD and the VA on the site in this new collaboration will produce these economies of scale. The approach in the implementation of this project should be one of looking for the maximum opportunities for sharing rather the minimal opportunities for sharing.

The Effort to Make It Happen

The last three years have been marked by extraordinary effort by all parties to see this opportunity realized. Although there were some conceptual issues early on, the current plan to build on the Fitzsimons campus a "Federal Health Care Tower" housing the DVAMC and the

military treatment facility that would have been built at the Buckley Air Force base, and to have them connected to and sharing with the University of Colorado Hospital is unprecedented. Much of the relationship and sharing that has taken place in the past we will be continued and enhanced. Ninety percent of the physicians that practice at the DVAMC have School of Medicine faculty appointments. Many of their physicians currently see patients at DVAMC then walk across the green space to see patients at University of Colorado Hospital and vice versa.

New opportunities will be available. The partnerships will be strengthened and a new model for collaboration created. There will be available on one campus coordinated care for the citizens of Colorado, for veterans from several states, care for our active duty men and women, and the major TRICARE provider for Colorado (UCH) providing care to the families of our active duty and the retirees from our armed services.

The Fitzsimons Campus Today

Already Fitzsimons is synonymous with state-of-the-art health care, providing medical services unique in a five-state area. To date, it is:

- A $1.3 billion project with the funding secured (not including The Childrens Hospital and the Federal Tower)
- Three years ahead of schedule on a 12-year plan
- Two million square feet are completed, one million under construction and another million to start in the next six to nine months.

Already completed are:

- The University of Colorado Hospital's Anschutz Outpatient Pavilion
- The University of Colorado Cancer Center
- Rocky Mountain Lions Eye Institute
- Anschutz Inpatient Pavilion – Phase I (opened February 2004)
- Ben Nighthorse Campell Native American Health Center
- A 180-bed state veterans nursing home.

This summer, the university will cut the ribbon on two research towers. A new dental school is under construction, as is the Marion Downs Hearing Center and the Barbara Davis Center for

Childhood Diabetes. The Children's Hospital held groundbreaking ceremonies June 10: and a biosciences research park, town center and hotel facilities are underway. Light rail will also connect the campus with downtown, the greater Denver metro area and Denver International Airport.

The University of Colorado Hospital's Board of Directors on June 22 authorized the acceleration of several of the hospital's projects, taking advantage of current low interest rates to complete its move by early 2007. This includes the build-out of the 12-story inpatient tower already partially occupied, the building of the Center for Dependency, Addiction and Rehabilitation (CeDAR), and office buildings and parking structures.

With the campus filling up sooner than anticipated, cautious planning is needed to maximize the remaining site. There no longer is sufficient land for entities to build separate stand-alone facilities. They must be shared.

The Federal Tower

A federally owned clinical tower at Fitzsimons would provide a federal facility for federal employees to care for veterans, and DoD active duty and TRICARE beneficiaries. The federal government will retain ownership, governance and management of the federal tower and the underlying land would be made available through the use of a long-term ground lease.

The tower would house all VA and DoD functions except those shared and would have a separate identity with separate access, parking, way finding and unique services. Care would continue to be provided for and/or directed by VA and DoD physicians.

Shared services and functions with University of Colorado Hospital could include operating rooms, recovery rooms and highly specialized surgeries and intensive care beds; specialized care in GI, cardiology and oncology; OB/GYN services; dietetics; specialized imaging and laboratory services; physical plant operations and parking. Additionally, economies of scale, including significant savings can be found in sharing warehousing, materials management, sterile processing and administrative space.

Long-term care beds and sub acute/rehab beds would be located near the new state veterans nursing home that is about 100 yards from the Federal Tower. VA research space could be co-located with the Health Sciences Center in a new research tower located approximately 150 yards from the Federal Tower.

Sharing University of Colorado Hospital clinical facilities and Health Sciences Center research facilities would achieve unprecedented economics of scale. For example, University of Colorado Hospital is considering leaving its clinical lab in the basement of a building on the old campus, as labs do not need to be located on-site. By not building one in the new hospital building, the hospital can save $6 million or more. If the VA elects to share University of Colorado Hospital's clinical lab rather than building one in the federal tower, it could save $4 million or more. If the Air Force does the same, it, too, will save millions. By using an existing asset and bringing the volumes together, the joint savings could be as much as $10 million in capital costs alone. By combining labs, the equipment could be used more efficiently resulting in significant operational savings for years to come. The issues of management and personnel can be worked out with mutual protection of all parties.

The Benefits of the Federal Tower with Shared Services and Functions

Many veterans groups have told us that Fitzsimons is a friendly site for veterans, who like the way the old army base is being revitalized. They have said they appreciate the potential for the VA and DoD to learn from the university and for the university's willingness to learn from the VA and DoD.

The United Veterans Committee of Colorado, representing more than 400,000 veterans, approved a resolution supporting the relocation to Fitzsimons. Among the major points cited were:

- the effective partnerships between the VA and University of Colorado Hospital, which incorporates facilities, equipment and physicians with dual appointments
- the need to restore or replace the current VA facility
- the hardships for staffs to travel between sites
- loss of shared facilities and equipment to VA, causing expense for replacement.

What's Next

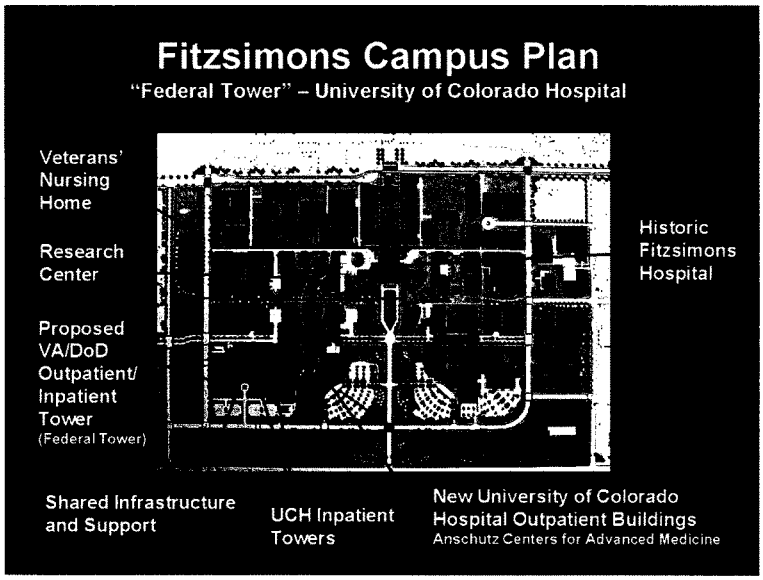
The Department of Defense, the Department of Veterans Affairs and the US Congress have authorized the building of the federal tower at Fitzsimons. By locating the tower by UCH and sharing services and functions yet maintaining separate identities the qualitative and financial savings will accrue to all entities, and provide outstanding research and educational facilities and state-of-the-art health care for veterans, DoD beneficiaries and the citizens of Colorado and surrounding states.

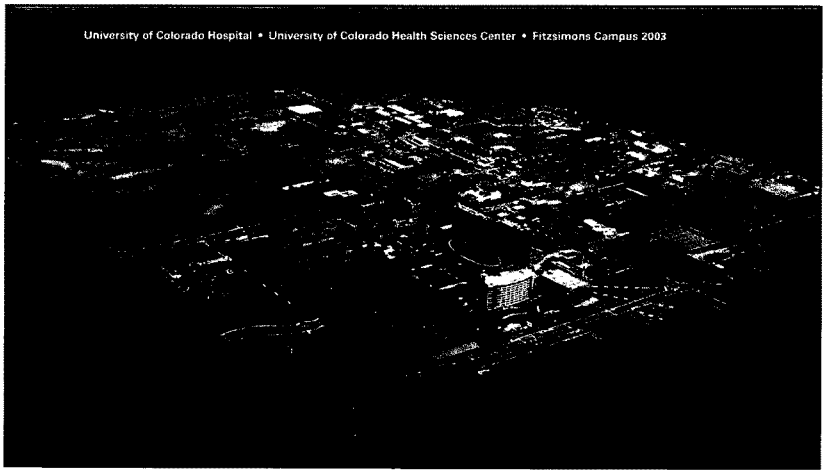
University of Colorado Hospital and Health Sciences Center, the VA and the DoD must continue to work together to resolve critical relationship issues relating to the implementation of this plan including the sharing of facilities and services.

Together with the DoD and the VA, we have the rare opportunity to create a new national model of care for veterans, DoD beneficiaries and UCH patients. One that offers flexibility and quality care in a state-of-the-art facility while offering long-term cost savings to the federal government and to University of Colorado Hospital and the Health Sciences Center.

It is a once in a lifetime opportunity to enhance and expand upon already successful partnerships – one that was started more than half a century ago.

Mr. Chairman, this concludes my statement. I will be pleased to respond to any questions you or the members of the Committee may have.


Fitzsimons Campus Plan
"Federal Tower" – University of Colorado Hospital
Veterans' Nursing Home
Research Center
Proposed VA/DoD Outpatient/ Inpatient Tower
(Federal Tower)
Historic Fitzsimons Hospital
Shared Infrastructure and Support
UCH Inpatient Towers
New University of Colorado Hospital Outpatient Buildings
Anschutz Centers for Advanced Medicine


University of Colorado Hospital • University of Colorado Health Sciences Center • Fitzsimons Campus 2003

Dennis C. Brimhall has been President and Chief Executive Officer of University of Colorado Hospital since 1988. Today, University of Colorado Hospital serves as the regions and one of the nations leading tertiary/quaternary health care providers. University of Colorado Hospital is the University of Colorado Health Sciences Center main clinical facility for teaching and research.

A native of Provo, Utah, Mr. Brimhall earned an undergraduate degree in zoology from Brigham Young University in 1972 and a master's degree in management from the Kellogg School of Management at Northwestern University in 1974. In 1974, he joined the University of Utah as Assistant Administrator, and then became Associate Administrator.

Before joining University of Colorado Hospital in Denver, he was Associate Director for the Medical Center at the University of California at San Francisco, where he worked for five years.

His professional activities include the Chairman of the Board of Directors of Novation, a member of the Executive Committee of the University HealthSystem Consortium, a member of the Board of Directors for TriWest Healthcare Alliance (A TriCare contractor). He has served as Past Chair of the Board of Trustees of the Colorado Hospital Association, Past President of the Colorado Children's Campaign, Past Chairman of the Governor's AIDS Council and Past Chairman of the Board of the National Conference for Christians and Jews. He is currently the Chairman of the Board of Directors of the Mile High United Way, is involved with Boy Scouts of America and the Fitzsimons Rotary Club. He is involved with church activities and with health care projects in Central Mexico and Biratnagar, Nepal. Mr. Brimhall and his wife Linda have four children and live in Englewood, Colorado.

6/2004

Disclosure

The University of Colorado Hospital is currently negotiating a contract with the Air Force (DoD) to lease approximately 7,490 square feet of space in its Anschutz Outpatient Pavilion on the Fitzsimons campus. This space would be used by the medical detachment at Buckley Air Force Base to house its primary medical care practice.

This lease is in anticipation of the construction of the Federal Tower on the Fitzsimons campus at which time the Air Force would relocate to the Federal tower.

The estimated annual value of this lease is $142,310.

Statement of
Lawrence A. Biro
Director, VA Rocky Mountain Healthcare Network
Veterans Health Administration
Department of Veterans Affairs
before the
Subcommittee on Health
Committee on Veterans' Affairs
United States House of Representatives

June 24, 2004

Mr. Chairman and Members of the Subcommittee:

Thank you for this opportunity to appear before you to present my views on the potential sharing agreement with DoD on the Fitzsimons campus. I am Lawrence A. Biro, Director for the VA Rocky Mountain Healthcare Network, Veterans Integrated Service Network (VISN) 19. VISN 19 serves an area covering the state of Utah, most of Montana, Wyoming and Colorado, and portions of Idaho, Kansas, Nevada, Nebraska, and North Dakota. This network provides healthcare for approximately 140,000 veterans at six medical centers and 32 Community Based Outpatient Clinics (CBOC).

In his May 2004 CARES Decision document, Secretary Principi made the following decision concerning the building of a new healthcare facility in Denver. I quote from the Decision document:

> "VA will build a replacement VA medical center through a sharing agreement with DoD on the Fitzsimmons [sic] campus with some shared facilities with the University of Colorado."

The Federal facility at Fitzsimons is a Joint Venture concept based in part on the VA/Air Force work in Las Vegas, Nevada and Albuquerque, New Mexico. As planned, this facility will be a Federal tower housing the medical services of Denver VAMC and the medical services of Buckley Air Force Base. The Air Force will occupy approximately seven percent of the building for clinical and administrative purposes.

The new facility will expand the capability of the Denver VA Medical Center by significantly increasing the amount of space available for clinical

services. Among services being considered, a new spinal cord injury center will be a part of this new facility, and other expanded clinical services, such as a 20-bed sub-acute care unit. In addition, a new 60 bed VA Nursing Home Care Unit will be located on the Fitzsimons campus.

This relocation is also intended to maximize efficiencies within the Federal tower by working closely to share some facilities with the University of Colorado Hospital. To obtain these efficiencies the new Federal tower must be located as near as possible to the existing and planned facilities of the University of Colorado Hospital. To that end, the University of Colorado Hospital has reserved a plot of land in close proximity of the existing and planned structures of the medical center.

This move to the Fitzsimons Campus makes complete sense. The University of Colorado Health Sciences Center and the University of Colorado Hospital (UCH) are totally committed to this site. Their outpatient complex is now complete and in operation. There is extensive research space that is near completion. The close proximity in conjunction with this well-established and long-standing affiliation will allow the use of university expertise for hyper acute and highly specialized care.

Acquisition of this property could occur through a long-term lease with the University of Colorado. VA's General Counsel has advised us that VA currently lacks authority to enter into long-term leases that would give the Department sufficient interest in the land to allow VA to build a facility here, which we estimate may cost $328 million. For a project of this magnitude, I believe that authority for a lease of much greater duration would be needed to ensure the government has sufficient interest in the land.

If we cannot obtain a long-term lease, we will be forced to look for land that the government can purchase outright on or close to Fitzsimons. Although the new facility would continue to be a joint Federal health care tower between VA and the Department of Defense, our opportunities to gain greater efficiencies through sharing arrangements with the University of Colorado might be more limited. Therefore we are grateful to the Committee for introducing legislation

that contains a provision that would assist us in relocating to the Fitzsimons Campus of the University of Colorado.

Mr. Chairman, this concludes my statement. I would now be happy to answer any questions you and other Members of the Subcommittee might have.

Preserving America's Heritage

Testimony for the Record

Submitted by John L. Nau, III
Chairman, Advisory Council on Historic Preservation
To the Honorable Rob Simmons, Chairman
Subcommittee on Health
Committee on Veterans Affairs

Hearing on Draft Bill, Department of Veterans Affairs
Real Property Facilities Management Improvement Act of 2004

Thank you Chairman Simmons and members of the committee for inviting me to testify before you today regarding the Department of Veterans Affairs' Capital Assets Realignment for Enhanced Services (CARES) program.

My name is John L Nau, III. I was appointed by President Bush in 2001 as chairman of the Advisory Council on Historic Preservation. The ACHP is an independent Federal agency, created by the National Historic Preservation Act of 1966, to advise the President and Congress on historic preservation matters.

We also administer the portion of the National Historic Preservation Act that deals with review of Federal agency programs and projects that have the potential to affect historic properties. In this latter capacity, the ACHP has long been aware of the rich inventory of historic assets managed by the VA. Likewise, we are familiar with the challenges VA confronts with the use of these properties to provide first-rate health care to our Nation's veterans.

Recently, the White House has launched a major historic preservation initiative, entitled *Preserve America.* The initiative is designed to promote the appreciation and use of our Nation's heritage assets in a manner that ensures both their long-term preservation and their continued contribution to the economic vitality of the country.

Preserve America has several components that advance these goals, including a community recognition program for *Preserve America* Communities, a Presidential awards program that recognizes outstanding historic preservation achievement, and partnership efforts with the Gilder

ADVISORY COUNCIL ON HISTORIC PRESERVATION
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Lehrman Institute of American History and the History Channel to promote public understanding of and appreciation for our heritage.

Of particular relevance to the VA's management of historic properties is Executive Order 13287, *Preserve America,* which was signed by the President on March 3, 2003. The ACHP has been tasked with implementing key provisions of the order that pertain to improving Federal stewardship of historic properties.

The overall thrust of the Executive order is to encourage Federal agencies to manage their historic properties in a way that advances the economic health of the community in which they are located and that also promotes their preservation over the years. Central to this goal is the development of partnerships with State and local governments and the private sector. It is from this perspective of national historic preservation policy that the ACHP presents its views on the legislation being considered by the committee.

We would also note that the ACHP played a significant role in the implementation of the Department of Defense's Base Realignment and Closure (BRAC) program when it was initiated 10 years ago. The military services frequently identified historic properties in complying with the requirements of the National Environmental Policy Act and National Historic Preservation Act.

In an effort to streamline the review required under the National Historic Preservation Act, we developed a modified review system that expedited decisionmaking while providing effective consideration of preservation issues and options. Transfer agreements included provisions for standard mitigation, including preservation covenants, and creative mitigation strategies that were tailored to the unique historic or architecture character of the installation.

We also worked closely with the military services and local redevelopment authorities created under the BRAC legislation once property was conveyed to them. By having early and continuous stakeholder involvement, the ACHP and other preservation organizations were able to identify the benefits of historic preservation in the marketing of installations. Historic preservation thus became a tool rather than an impediment—with the local redevelopment authorities advancing the use of historic tax credits, easements, and other Federal grants and loans targeted for preservation and rehabilitation.

The ACHP has monitored the evolution of the VA's CARES program since the draft National CARES Plan was presented to the CARES Commission on August 4, 2003. The ACHP's interest was based on the potential impact on VA resulting from the divestiture of a considerable amount of Federal real property, a majority of which may be historic. In addition, we were concerned about the impact of the CARES program on local communities. The Honorable Robert Young, mayor of Augusta, Georgia, is a member of the ACHP and has expressed concerns about the impact of consolidating facilities on the local government as well as veterans and service providers.

It is our understanding that the primary focus of the CARES program is to adapt the VA's current infrastructure to its future needs. The specific components of this plan that are of interest to the ACHP include the elimination of hospitals in areas where there has been a decline in the

client base and the construction of new facilities and the consolidation of existing programs needed to improve the delivery of services in areas with an expanding veterans population. All of these activities have the potential to greatly impact historic properties, which were constructed to serve the needs of the veteran population of earlier times.

We support the VA's initiative in creating the CARE's program; it is consistent with the goals and objectives of the President's Management Agenda, OMB mandated strategic planning, and other government-wide initiatives geared toward improving Federal program delivery, capital asset management and real property accounting and stewardship.

The ACHP is well aware of the need for many agencies to excess underused property that no longer supports the agency mission. The background provided on the CARES program, however, does not address how possible closings, demolitions, property transfers, infrastructure improvements, and other related activities of facilities would impact historic properties. All Federal agencies hold these properties in trust for the American people and, as the Administration has so strongly emphasized in the issuance of Executive Order 13287, appropriate stewardship of these irreplaceable resources is a government-wide priority.

VA controls the fourth-largest inventory of owned, leased, and operated Federal real property. It is estimated that more than half of the VA's facilities are more than 50 years old. Many date from the 19th century and many more were constructed in the late 1940s and early 1950s. Approximately 40 percent of the VA's medical centers are identified historic districts as defined by the National Register of Historic Places and contain more than 1,900 historic structures. In addition, a large number of properties are individually listed or eligible for listing in the National Register, including 119 national cemeteries and at least 32 archeological sites.

Given this rich array of heritage assets, there are five major issues that the ACHP would like to bring to the committee's attention regarding the CARES program. While many are related to the draft bill, some clearly have broader implications.

First, in reviewing the draft CARES plan, we noted that over the next 20 years it is anticipated that approximately $4.7 billion in capital assets will be needed to implement this program. This estimate includes $59 million earmarked specifically for demolition costs. We are concerned that if the VA is predisposed to demolition of facilities and funding for such is readily available, agency officials will not be receptive to proposals for historic properties that involve leasing, adaptive reuse, or partnerships with health care providers or State, local, or tribal governments.

Second, we understand that the VA intends to unilaterally coordinate the transfer of real property related to the implementation of the CARES program. We would hope that the VA would draw on the experience of other Federal agencies that have dealt with excess historic properties, such as the Department of Defense and the General Services Administration, for technical assistance in carrying out this assignment.

The transfer of real property, particularly historic properties, can prove challenging, especially when the unique aspects of the historic property are not properly considered when negotiating covenants and establishing fair market value. We would like VA to give full consideration to the

values that are inherent in the adaptive reuse of historic properties. The ACHP recognizes that historic properties are assets often blessed with inherent values that are absent on newer or less distinguished structures.

Third, the draft House bill authorizes the VA to use the proceeds from the transfer of real property for maintenance and repair and improvements to facilitate transfers, as well as related administrative expenses. It provides for remaining proceeds to be used for historic preservation associated with National Register properties or to which compliance with Sections 106 and 111 is required.

We applaud the availability of funds for maintenance and repair and are hopeful that the success of the CARES program will spearhead an aggressive maintenance and repair program within the VA that focuses on historic properties. However, we are concerned that the bill as drafted places the use of such proceeds at the end of the line and the possibility that all funds are used for other purposes, including actions that might be contrary to achieving preservation solutions, may well lead to no resources being available to carry out the intent of this provision.

We are also concerned about the role of stakeholders in making determinations regarding the feasibility of repair versus demolition. We believe that if VA would allocate resources to stabilize and repair historic properties with reuse potential, health care providers, local governments, veterans' organizations, and other entities with VA-related functions would consider lease arrangements that would be mutually beneficial.

Fourth, the draft bill is silent on the obligation of VA to comply with the government-wide process for considering the impacts of its transfer actions on historic properties as mandated by Section 106 of the National Historic Preservation Act. The ACHP believes that the proposed legislation provides an opportunity to encourage VA to engage the Section 106 process in early planning so that balanced decisions about the future of the VA's heritage assets and full exploration of opportunities to achieve desired goals are efficiently integrated into the disposal process.

Fifth, although the CARES program does not specifically address environmental and preservation concerns associated with new construction and expanded or upgraded infrastructure, VA needs to be aware that planning and site selection for new facilities may have an effect on historic properties. Not only can such project have a direct effect on historic properties when demolition is required to prepare a site, the design of new buildings may also require coordination as many of VA's existing facilities include historic districts. This may require that design guidelines take into account the architecturally defining characteristics of adjacent buildings.

In closing, we recommend that, in formalizing the VA CARES implementation process, the committee integrate historic preservation concerns and processes to maximize the contribution VA's significant historic properties can make to local communities. A properly crafted process can encourage transfer of historic properties where the new owner is committed to a long-term preservation strategy; minimize neglect while properties await disposition; promote partnerships

for creative use or cooperative management arrangements; and effectively involve the local community in reuse strategies that promote economic development.

We appreciate the opportunity to share our views with the committee and look forward to working with you in finalizing legislation that properly integrates historic preservation opportunities into the CARES program.

STATEMENT OF DENNIS SAMIC
BEFORE THE HOUSE VETERAN AFFAIRS
SUBCOMMITTEE ON HEALTH
24 JUNE 2004 LEGISLATIVE HEARING

Mr. Chairman, Ladies and Gentlemen of the Subcommittee,

My name is Dennis Samic. I appreciate the opportunity to appear before you today, to provide input to your deliberations regarding a Draft Bill on capital leases, enhanced-use lease authority and capital asset/construction matters.

I am a retired AF Brigadier General who served nearly 30 years on active duty, but I'm here today as a member of the Board of Trustees for the American Veterans Heritage Center (AVHC), a four year old, Dayton, Ohio based non-profit organization. The mission of the American Veterans Heritage Center is to increase awareness of veteran's issues, recognize veteran's contributions, endorse patriotism, promote tourism, and enhance our neighborhood by preserving and developing the Dayton, Ohio Veteran's Affairs Historic District.

I don't envy the task before you—the Draft Bill you're considering may well require the Department of Veterans Affairs to spend some portion of their already tight appropriated funds to identify, stabilize, and repair the most historically significant of the nearly 2000 facilities located on their medical campuses across the country. Many constituencies will be impacted by your decisions and the VA's implementation of any final legislation. Since these constituencies have varied opinions as to the value of spending VA resources on old buildings instead of medical care, Secretary Principi and his staff, members of this subcommittee, and your colleagues in Congress will have to make some difficult tradeoffs, which I'm certain won't please everyone.

I suggest, however, that despite the many differences of opinions on this issue held by individual veterans and the veterans service organizations that represent them, all veterans and VSOs agree on several things:

1. They want their service to and sacrifices for our nation to be appreciated by our citizens.
2. They want their service and sacrifices, and that of military members who come both before and after them, to be remembered.
3. They want their service and sacrifices to be a legacy which inspires future patriotism.

The American Veterans Heritage Center believes one of the best ways to honor our veterans and preserve their legacy is to rehabilitate and utilize many of the significant historic facilities owned by the VA. Preservation of historic facilities and structures owned and operated by the VA is a national issue in its scope. We believe the approach our community took and continues to pursue could serve as a possible guideline for a federal or national policy; we also hope our approach may be instructive for other communities as they develop their public/private partnerships.

It is especially fitting for the Dayton, Ohio community to address the need for historic preservation because the Dayton VA Campus is the foundation for modern VA health care.

- President Abraham Lincoln established the National Home for Disabled Volunteer Soldiers on March 3, 1865, to care for disabled veterans of the Civil War. The Dayton Soldiers Home, now called the Dayton VA Medical Center, was one of the original three facilities established - including Milwaukee, WI and Togus, ME - and it was the first to provide the "home-like" environment envisioned by the Board of Managers. The Dayton facility was referred to as the "Mother Home".
- The groundbreaking approach to veteran's care initiated at the Dayton Soldiers Home influenced the evolution of Federal Policy for the care of our nation's veterans. Prior to the National Home for

Disabled Volunteer Soldiers, state and local governments were relied upon to provide for care of the needy.

- The National Home for Disabled Volunteer Soldiers demonstrated that the federal government is capable of providing comprehensive care and rehabilitation to a large number of veterans, establishing a significant Federal role for the care of the nation's veterans and serving as a forerunner for many of today's social programs, including Medicare and Social Security.
- Over its history, the National Home for Disabled Volunteer Soldiers evolved programmatically and physically to meet the changing needs of the nation's veterans. Congressional actions in 1884, allowed veterans disabled by old age or disease to apply without having to prove any service-related disability; and in 1917, Congress stipulated that all veterans were entitled to medical, surgical, and hospital care showcasing the evolution of Federal responsibility for the nation's veterans.
- The design of the various National Home for Disabled Volunteer Soldiers branches includes individual structures, which stand out for their history or design significance and integrity.
- The Department of Veterans Affairs has taken initial steps to safeguard this heritage by either listing each of the now eleven National Home for Disabled Volunteer Soldiers properties on the National Register of Historic Places, or determining their eligibility for listing. However, it is clear from the research completed by the Department that the full scope and national significance of the National Home for Disabled Volunteer Soldiers within the context of our Nation's history has not been assessed.

Some definitive action is needed to stimulate national preservation efforts and establish momentum.

- While the American Veteran's Heritage Center supports the draft bill before us here today we have very basic concerns about how such a bill would be implemented, how the Capital Asset Fund would

be utilized and what can be done to make the Enhanced Use Lease program more effective. The disposition of those buildings that are either listed on, or eligible for listing on, the National Register should be given serious consideration by the sub-committee. It is essential that the properties owned by the Veterans Administration, with the most historic character receive the proper attention that they deserve. To ensure that this important part of our nation's heritage is preserved and protected, we urge your committee to include in your Bill an incentive, if not a requirement, for the Department of Veterans Affairs to more actively partner with the National Park Service to prepare an Assessment of Significance of the National Home for Disabled Volunteer Soldiers to determine which of the historic facilities are the **most historic**. Working with the National Park Service, the VA should prepare one or more National Historic Landmark nominations for the properties that best illustrate or commemorate this story. The goal is to keep the most historically significant buildings from being torn down before preservation can start.

- This Assessment should provide a narrative historic context that outlines the history, events, and persons associated with the administrative and physical development of the National Home for Disabled Volunteer Soldiers. In addition, the documentation should describe the physical characteristics of each property selected for nomination and how those features illustrate the National Home for Disabled Volunteer Soldiers story.
- This Assessment and preparation of National Landmark nominations is consistent with the language and intent of the Historic Sites Act (1935), the National Historic Preservation Act (1966), with Executive Order 13287 – Preserve America (March 3, 2003), and with HR 1762, the Veterans National Heritage Preservation Act of 2003. And, the legislation you're considering would add to the VA's imperative to preserve its history.

As you mark up your Bill, we urge you to incorporate as many of the provisions as you can of HR 1762 introduced by Congressman Turner. For example:

- Once the Assessments of Significance I mentioned earlier are completed, we urge your committee to require the VA to fund the creation of a master utilization plan for their campuses; such a plan for the Dayton VA campus could serve as a pilot for future such plans at other campuses.
- While we applaud the establishment of a VA Capital Asset Fund, the bill you are considering establishes a priority for use of the fund that will make it difficult, if not impossible, for the funds to be used for historic preservation. Environmental clean-up, maintenance and repair, and other costs for current and future transfer of assts have priority over historic preservation. We urge you to establish a guaranteed percentage, perhaps 25%, that could be used for historic preservation. Without that guarantee, the fund will probably not be used for historic preservation.
- The draft bill gives the authority to transfer property below fair market value for the purposes enumerated in Title 28, Chapter 20 of the United States Code. This chapter deals with benefits for homeless veterans. We urge you to include historic preservation as a purpose for which property can be transferred below fair market value. Under this change, a historic building could be transferred to an organization which could maintain the historic significance of the building as a condition for receiving the property.
- Finally, the bill describes a process for transferring real property. That process includes a series of notification steps. We urge you to include in one of those notices, a statement certifying that the transfer would have no impact on a building on the National Register of Historic Places (or eligible for such listing); and if the transfer would have an effect, the department should state that it has found no adaptive reuse for the building. This will provide the department with an incentive to seek new uses for existing historic buildings.

We understand that Secretary Principi is about to sign a request to the Director of the National Park Service to begin an Assessment of Significance for all eleven sites associated with the Home for Disabled Volunteer Soldiers, and we are pleased about that. If it is completed and the VA identifies its most historically significant facilities, the VA can initiate development of local master utilization plans for each facility as discussed earlier. Creative local partnerships between local VA organization, VSOs, state and city officials, non-profit organizations, the National Parks Service and private individuals and foundations can be established to implement those plans.

We have such a partnership in Dayton, Ohio and Secretary Principi was kind enough to "cut the ribbon" on our American Veterans Heritage Center Office in April of last year and we are making further progress. Our Dayton VA campus has been added to the National Historic Register and we look forward to historical landmark status. We are rehabilitating the first permanent chapel built by the United States Government, and in the long term want to turn the Dayton VA's historic chapel, patient library, administration building, and barracks into a National Veterans Hall of Fame to honor veterans and educate the nation's youth on the value of patriotism.

We appreciate you holding these hearings to gain stakeholder input. We don't believe the VA will receive a large enough appropriation to provide for all the costs of both health care and preservation. We do believe, however, that with your help and direction, the VA will devote enough of the money it has to stabilize its historic facilities and fund master utilization plans for its campuses. If the VA then encourages creative local partnerships, which use these master utilization plans to build business cases to stimulate contributions, together we can satisfy the needs for both outstanding health care and preservation of these national treasures. Some will view the expense associated with these recommendations as a cost. We view them as an investment that will significantly reduce the fiscal

burden the VA faces today to maintain buildings no longer needed for patient care, while allowing our nation to provide those few things all veterans want and deserve—thanks, remembrance, and a legacy.

Preservation is such an important issue; we suggest this Subcommittee consider separate hearings just to this topic.

Thank you for the opportunity to appear.

RESUME

Dennis R. Samic, BGen USAF (Ret.)
Fairborn, OH 45324

May 2000 to Present: CACI, Inc.-Federal; Vice President. Has P&L responsibilities for three company directorates with activities in five geographic areas providing system support to Air Force, Navy, Marines, and State of Ohio organizations. In addition, as the senior CACI official in Ohio, Mr. Samic integrates the efforts of a 320-person office with representatives from all five of CACI's US business groups.

1995 - 2000: Air Force Materiel Command, WPAFB OH; Chief Financial Officer. Mr. Samic was CFO of a $35.5 billion, 90,000-person provider of research and development, weapons systems acquisition and testing, materiel management, and major depot maintenance for the Air Force, other Department of Defense, and foreign military customers. He led a 190-person, 5-Division Organization, responsible for all fiscal issues. Mr. Samic installed an integrated cost accounting capability and cost reduction culture across the organization while improving product quality and timeliness for our customers.

1992 - 1995: Air Education and Training Command, San Antonio, Texas; Chief Financial Officer. Mr. Samic was CFO of $6.8 billion provider of flight training, technical training, and professional education to over 300,000 Department of Defense students annually. He led an 85-person, 4-division organization which made current and long-range policy and operating decisions for all fiscal matters. Mr. Samic provided financial direction for integration of the Air Force Institute of Technology into the Command. He focused attention on activity-based management of student costs and operating cost reductions at the largest medical facility in the Air Force, Wilford Hall Medical Center.

1990 - 1992: Air Mobility Command, O'Fallon, Illinois; Assistant Chief Financial Officer. Mr. Samic served as senior financial manager of an $8.1 billion organization. He managed a 90-person financial organization which provided world-wide airlift of Department of Defense personnel, patients, and materiel. He was project leader in identifying and reporting all revenue and recouping all costs associated with the most intensive airlift operation since Berlin - Operation DESERT STORM.

1989 - 1990: Alaskan Air Command, Anchorage, Alaska; Chief Financial Officer. Mr. Samic led a 50-person staff managing an $850 million annual program used to finance fighter aircraft and radar operations. He was responsible for financial support to the government-wide effort to cleanup the Valdez, Alaska oil spill.

1986 - 1988: Pentagon, Washington D.C.; Executive Officer to Comptroller of the Air Force. Mr. Samic was directly involved in all financial policy issues for the Air Force. He orchestrated interfaces with the Congress, Office of the Secretary of Defense, other services, and all the Air Force's Major Commands. He

was project officer for the development of the Air Force's long-range automated financial systems architecture.

1985 - 1986: Pentagon, Washington D.C.; Chief of the Air Force Comptroller's Financial Information Systems Office. Mr. Samic was responsible for developing the comptroller's Air Force-wide information system architecture.

1981 - 1985: Air Force Accounting and Finance Center, Denver, CO; Chief of Air Force Retired Pay. Mr. Samic led a 120-person organization which paid the Air Force's 560,000 retirees.

1977 - 1980: Army and Air Force Exchange Service, Dallas, TX; Financial Analyst and Assistant Chief of Staff. Mr. Samic was responsible for an organization that employed 60,000 people, operated 16,000 stores and sold $3.2 billion in retail goods and services annually.

1970 - 1977: Base and Major Command Levels with Air Force. Mr. Samic served as Budget Analyst during this time in various financial positions as base and major command levels.

EDUCATION:

University of Southern California	1973	MS in Systems Management
Ohio State University	1970	BS in Corporate Finance

American Veteran's Heritage Center's
Save America's Treasures Grant
From the National Park Service

The American Veteran's Heritage Center received a three year $130,000 Save America's Treasures Grant from the National Park Service on 9 August 2001. The grant was provided to repair the floor in the Dayton VA chapel, and was only available to the extent that American Veteran's Heritage Center raised matching contributions, in-kind or cash. We have successfully raised these matching contributions, and have obligated $121,088 of the grant for floor repair. Currently the American Veteran's Heritage Center is working with the National Park Service to extend the grant timeline and expand its purpose to allow us to spend the balance on other chapel repairs.

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Testimony

of

Richard "Rick" Jones
AMVETS National Legislative Director

presented to the

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

on

Draft Legislation to authorize capital leases, changes to the enhanced-use lease authority, capital asset and construction matters and for other purposes

Thursday, June 24, 2004
9:30 am, Room 334
Cannon House Office Building

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

On behalf of AMVETS National Commander S. John Sisler and the nationwide membership of AMVETS, I am pleased to offer our views to the Subcommittee on Health regarding draft legislation to authorize capital leases, changes to the enhanced-use lease authority, capital asset and construction matters and for other purposes. Thank you for this opportunity.

Mr. Chairman, AMVETS is a staunch advocate of providing veterans with appropriate benefits and services *earned* through honorable military service. As a leader since 1944 in helping to preserve the freedoms secured by America's Armed Forces, our organization continues its proud tradition, providing not only support for veterans and the active military in procuring their earned entitlements but also an array of community services that enhance the quality of life for this nation's citizens.

AMVETS applauds this Subcommittee and its effort to identify, examine and pursue legislative initiatives to implement solutions necessary for veterans to obtain the services, benefits and assistance they merit, earned and richly deserve.

Regarding the matter at hand, AMVETS supports the numerous leases authorized for contract in the draft bill. Ensuring sponsorship of these outpatient and related healthcare facilities will help address the quality and appropriateness of medical care service for sick and disabled veterans. These facilities will help maintain VA congressionally mandated missions of sustaining health care delivery for America's veterans, regionally and demographically.

We have learned important lessons over the years that the establishment of

health care clinics helps pave the way toward a comprehensive solution to veterans health care needs. Strengthening clinical services, as this draft legislation would, should help continue VA's effort to change with the times and attain the quality health care programs that will significantly affect veterans' care. We trust that Congress and VA will also work together to provide a health care system that meets the specialized needs of veterans as well.

The draft bill also contains language to establish a Department of Veterans Affairs Capital Asset Fund in the Department of the Treasury. Under the proposal, this Fund would receive proceeds from a disposal of VA real property by sale, transfer or exchange. Proceeds retained within the Fund would be used for the costs of actual or planned disposals of real estate, including demolition, environmental cleanup, necessary improvements to facilitate the sales, transfers or exchanges and administrative expenses. And, the Fund would be available for use to improve non-recurring VA capital projects.

Finally the draft language terminates the Nursing Home Revolving Fund, transfers remaining funds to the Capital Asset Fund, and authorizes to be appropriated to the Fund $10 million.

AMVETS supports these provisions because they would facilitate VA's completion of transfers and disposals. And, the provisions provide for an orderly process of notice, public hearings, and receipt of fair market value for disposals and transfers, while at the same time providing a funding mechanism for improving current facilities.

Mr. Chairman, as AMVETS understands Section 7 of the draft proposal, the Secretary of Veterans Affairs would be given the authority to continue to provide a veteran any of the services that could have been provided in a pilot program at the end of the pilot. AMVETS supports the inclusion of this provision

and sees the passage of this authority as a way to ensure that the rug will not be pulled out from under veterans in receipt of pilot-program services.

Mr. Chairman, we applaud your holding this hearing and thank the Subcommittee for extending us the opportunity to present our views on these matters. We look forward to working you and others to strengthen, enhance, and improve the earned benefits of our nations' veterans and their families.

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STATEMENT OF
JOY J. ILEM
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH
UNITED STATES HOUSE OF REPRESENTATIVES
JUNE 24, 2004

Mr. Chairman and Members of the Subcommittee:

Thank you for the opportunity to present the views of the Disabled American Veterans (DAV) and its Auxiliary, on the Department of Veterans Affairs Real Property and Facilities Management Improvement Act of 2004—draft legislation to authorize numerous capital leases, changes to the enhanced use lease authority, and other capital asset and construction proposals.

As an organization of more than one million service-connected disabled veterans, DAV has a vested interest in Department of Veterans Affairs (VA) plans to restructure its health care system under its Capital Asset Realignment for Enhanced Services (CARES) initiative. According to VA, the goal of CARES is to enhance access to health care services for our nation's veterans, while ensuring the integrity of its health care system. One of the most important VA benefits for service-connected veterans is health care. Access to high quality, timely health care services is essential for many DAV members, especially those who have suffered severe or catastrophic disabilities as a result of their military service. Therefore, preservation of the integrity of the VA health care system and its specialized programs is of the utmost importance to the DAV and our members.

It has been said that CARES is the most comprehensive assessment ever undertaken by VA to determine the capital infrastructure needed to provide modern health care to veterans now and in the future. We agree that the CARES process is extremely important as it will impact the system and the delivery of health care services to veterans for decades. Like veterans of previous wars, many of the men and women serving today in our Armed Forces in Iraq, Afghanistan, and other trouble spots around the world, will need and depend on the VA health care system for years to come. It is our obligation to ensure they have access to a strong and viable health care system, dedicated specifically to their health care needs.

Section 2 of the proposed draft legislation authorizes the Secretary of Veterans Affairs to enter into capital leases for 17 facilities with the authorization to appropriate funds in the amount of $27,020,000 for such leases. It also authorizes the Secretary to enter into a lease for real property located at the Fitzsimons Campus of the University of Colorado for a period up to 75 years. DAV Resolution No. 099 supports additional and separate funding for the building or leasing of VA Community-Based Outpatient Clinics.

Section 3 of the proposed measure would establish in the Treasury of the United States, a revolving fund known as the Veterans Affairs Capital Asset Fund (Fund), with any amounts in the Fund remaining there until expended. The measure would terminate the current Nursing Home Revolving Fund and transfer any unobligated balances from that fund to the newly established Capital Asset Fund as well as authorize $10 million to be appropriated for such Fund.

This section of the bill also includes authority for transfer of real property to other Federal, State, public and private entities if the Secretary receives not less than fair market value for such property with the exception of transfers to a grant and per diem provider. VA would be required, with respect to the transfer of any real property, to provide proper notification of the proposed sale, hold a public hearing, wait a specified period of time prior to actual sale, and notify the Congressional Veterans' Affairs Committees of the intent to dispose of the property.

DAV fully supports this provision that would allow for funds derived from lease or sale of VA property to be reinvested for the improvement of other VA health care facilitates. While the bill seeks to streamline the divestiture process, it does not specify how the funds collected from sale or enhanced use lease of property can be used. Congress must ensure the funds received from sale of properties are used only for their intended purpose, specifically infrastructure reinvestment. Additionally, continued oversight and proper notification of intent to sell is necessary to ensure VA receives fair market value of properties it intends to divest or lease. One major concern we have is that the Office of Management and Budget and the Budget and Appropriations Committees will propose that the funds received from the sale of VA properties be offset in the annual appropriation VA receives. We believe for CARES to be successful VA must be able to retain any funds from the sale of properties to pay for necessary infrastructure improvements. Likewise, VA should continue to receive funds for major and minor construction as well as spending for non-recurring maintenance to compensate for the years of neglect of VA infrastructure needs.

We are pleased the proposed legislation includes provisions that would allow funds to be used for preservation of historic properties. The protection and preservation of VA's historic structures is an important responsibility that the Department has ignored for far too long. *The Independent Budget* for Fiscal Year 2005 (IB), co-authored by American Veterans (AMVETS), DAV, Paralyzed Veterans of America, and the Veterans of Foreign Wars of the United States, recommends $25 million be appropriated to stabilize, preserve, and protect VA's historic structures. We encourage VA to consider a wide range of partnerships to accomplish these objectives, including partnering with other Federal agencies, nonprofit organizations, and the private sector. We support a comprehensive national program for VA to inventory its historic structures, and to establish broad classifications regarding their current physical condition and their potential for adaptive reuse. This bill would allow VA to use its Capital Asset Fund to complete renovation projects on historic structures so they can become assets rather than liabilities. We recommend the Subcommittee amend the legislation to strengthen the provision on historic preservation, making it more of a priority goal of enhanced use leasing authority.

Lastly, Section 3 contains provisions that would require VA to provide Congress with a plan and certification every six months of its compliance or non-compliance with the provisions

described under section 1710B of title 38, United States Code, concerning staffing and capacity levels for extended care services

DAV Resolution No. 096 supports legislation to establish a comprehensive program of extended care services for veterans in need of such care for a service-connected disability, and to any veteran who is in need of such care for any condition who has a service-connected disability rated at 50 percent or more. Maintaining proper staffing levels and capacity to care for veterans in need of long-term care services is essential given the record number of veterans age 85 and older in need of these specialized services. This provision will clarify VA's commitment to meeting the increased demand for post-acute and long-term care services.

Section 4 of the proposed measure would provide authority to use funds to construct or relocate surface parking incidental to a construction or non-recurring maintenance project. Although we have no resolution in support of this provision, we do not object to its consideration. Section 5 of the proposed measure would allow VA to proceed and provide necessary funding for an approved major medical facility project that has been authorized. Section 6 is a technical amendment that would improve VA's enhanced use lease authority by including language for land use under the current authority. Section 7 provides extension of the authority to continue to provide care and services to a veteran who is receiving care under an established VA long-term care pilot project. Although we have no specific resolution in support of the above four sections of the bill we do not have any objection to their favorable consideration.

The Department of Veterans Affairs Real Property and Facilities Management Improvement Act of 2004 would improve VA's authority to dispose of real property and streamline its Enhanced Use Lease program. The provisions contained within the proposed bill seek to address and improve the often cumbersome and time consuming process of selling, leasing, building, and improving VA health care facility structures. Ultimately, the goal of enhanced health care services for our nation's sick and disabled veterans and proper stewardship of the VA health care system is our main concern on behalf of the nation's 2.6 million disabled veterans. Therefore, we are able to support many of the provisions contained in the draft legislation.

In closing, DAV is looking to CARES to improve the infrastructure for the VA health care system so that it can best meet the needs of sick and disabled veterans now and into the future. As VA embarks upon this period of realignment and restructuring through the CARES process, the Administration, VA, and Congress must collectively work together to provide the resources necessary to see these improvements are realized. Likewise, we must remain vigilant to ensure the value of VA's physical assets are not wasted. Long term planning and oversight is essential as we enter this critical implementation phase. Proper maintenance and upgrades of many VA facilities are long overdue and it is strongly recommended these matters be addressed expeditiously. Finally, oversight by Congress, veterans, veteran service organizations and other interested parties will be essential to the success of CARES.

Again, we thank the Subcommittee for holding this hearing today and providing DAV the opportunity to express our views on this important issue.

Statement of

Richard B. Fuller
National Legislative Director
Paralyzed Veterans of America

Before the

House Veterans' Affairs Subcommittee on Health

Regarding

Draft Legislation Regarding VA Leasing of Facilities
Enhanced-Use Lease Authority, Capital Asset and Construction Matters

June 24, 2004

Mr. Chairman and members of the Subcommittee Paralyzed Veterans of America (PVA) is pleased to present our views on proposed legislation affecting various matters concerning property management of the Department of Veterans Affairs (VA) facilities. VA's significant inventory of real estate and physical infrastructure is a truly remarkable asset in the provision of health care and benefit delivery to veterans. At the same time, these facilities must be properly managed and cared

for to insure that the investment made in the use of these buildings and properties coincides with the benefits derived from their use.

Some years back, the General Accounting Office presented this Subcommittee with nothing more than a best guess "hunch" that VA was potentially wasting a significant amount of money on maintaining unused or underutilized facilities. Whether the scope of their report was accurate or not, the revelation sparked the move to conduct a bottom up and top down review of all VA facilities through the CARES process. PVA was generally pleased with CARES as long as the ultimate goal of the process was not just the closure of facilities but the general modernization and enhancement of services to veterans through a stronger and more efficient VA health care system.

The CARES report, in fact, called for strengthening one of VA's core missions, spinal cord injury (SCI) treatment centers. However, while recognizing the need for additional SCI centers, the final CARES decision document released in May of 2004 raised considerable concern within PVA because of its vagueness. The report stated that "VA will validate the number of SCI/D beds to ensure the appropriate need for and distribution between acute and long-term beds." The report also stated, "VA plans will include the potential for new SCI/D centers in Syracuse, Denver, Minneapolis and in VISN 16, and a certified outpatient clinic in Philadelphia, as well as expansions of existing SCI/D centers in Memphis, Cleveland, Augusta and Long Beach."

This new language citing "the potential" for expansion of SCI centers and beds and calling for further "validation" made PVA question VA's commitment to these much needed expansions. PVA had repeatedly provided the CARES commission with VA's own verified studies of demographics and needs based patient surveys clearly indicating these new and expanded facilities were fully warranted and justified.

On May 19th PVA leadership met with Secretary Principi to explain our concerns about further validation of the data and outlined the problematic CARES document language. We are pleased that the Secretary has agreed that the language was wrongly written and that it was not his intent to waver on the new SCI initiatives contained in the CARES report. The Secretary has assured PVA that the language will be corrected.

I mention this situation as an example of how PVA and this Subcommittee have to remain vigilant to make certain that the ultimate goal of the CARES process remains the enhancement of services to veterans. This will require continuing careful scrutiny and good faith on the part of the Administration, VA and Congress to provide the resources to see that these improvements are made. In the same manner, as the VA begins with the manipulation, sale or leasing of its infrastructure, facilitated in the legislation before the Subcommittee today, great care must me taken to ensure that the value and equity in VA's physical property

is not squandered. That equity does not belong to the VA or the Federal Government; it belongs to the veterans of the nation for their future good. With any rearrangement of VA facilities great care should be taken to make certain the present as well as the future needs of veterans are fully accounted for.

With that caveat, we believe the legislation before the Subcommittee does provide the VA with improved flexibility in leasing unused or underused properties. VA enhanced use lease authority is almost unique among other federal departments and agencies.
Unfortunately, however, the process has been called cumbersome and time consuming, discouraging VA Administrators from wanting to expend the effort to use this route in dealing with a property. Such a lengthy process also greatly discourages potential private sector entities from considering VA properties as a potential investment asset. This legislation authorizes the VA to further streamline the enhanced use leasing process to the benefit of both the VA and those in the private sector wishing to invest in VA properties. Likewise, it facilitates the process by which VA may dispose of properties ensuring that the proceeds are used to the future benefit of the veteran population.

The second major element in the legislation is the establishment of a Capital Assets Fund to serve as the repository for the proceeds from the sale or lease of VA properties and then acting as the conduit for the reinvestment of those proceeds for the improvement of other VA facilities. PVA strongly supports this

provision which would allow VA to keep the equity and the income from property it conveys, and, in the spirit of the CARES process, use those proceeds for the improvement of health care and benefit delivery for veterans. We have two areas of caution, however. First, VA, with proper Congressional oversight, must ensure that that VA receives fair market value and appropriate leases for these properties. Second, Congress, in authorizing the Capital Assets Fund must be very specific in defining what these funds can be used for. PVA has great concern, just as in the case of third party collections or any other alternative funding mechanism VA uses that the Capital Assets Fund might be looked upon by the Office of Management and Budget, Congressional Budget and Appropriations Committees as an alternative to, and not over and above regular funding for VA health care. We do not want to see VA major and minor construction funding or non recurring maintenance budget line items offset by Capital Asset Fund disbursements.

We would like to commend the Subcommittee for including historic preservation of VA structures as a recipient of Capital Asset Funding. The FY 2005 Independent Budget (IB) co-authored by AMVETS, DAV, PVA, and Veterans of Foreign Wars makes a very direct recommendation on the protection and preservation of VA's extensive inventory of historic structures. The IB recommended a $25 million VA fund for FY 2005 to be used to stabilize, preserve and reuse appropriate VA historic structures. Funds should also be provided to make grants to local and national non-profit organizations for

preservation activities related to VA facilities. The CARES Commission Report also recommended that VA move to address this issue. Without objection I would like to submit the The Independent Budget Historic Preservation Recommendations for the record as well as those citations on historic preservation in the CARES Commission Report.

VA owns almost 2,000 historic structures. Many are suffering from neglect and deteriorate further every year. VA has a moral responsibility to maintain these examples of the national legacy we share in caring for the American veteran. The Department is also bound by other federal statutes requiring it to care for them as well. Other federal departments and agencies have come to grips with this problem, finding alternative uses or divesting themselves of historic properties through leasing or sale. VA, if given the incentives can do the same. VA must inventory its historic structures and establish broad classifications regarding their current physical condition and their potential for adaptive reuse. The Capital Asset Fund is a logical source for renovation funding or stabilization for enhanced use leasing to help VA turn many of these structures from liabilities to assets. We strongly recommend that this legislation be amended to make historic preservation one of the optimum goals of VA enhanced use leasing authority.

This concludes my testimony. I will be happy to answer any questions you may have.

Preservation of VA's Historic Structures:

VA's extensive inventory of historic structures must be protected and preserved.

VA's historic structures provide direct physical evidence of America's proud heritage of veterans' care, and they enhance our understanding of the lives and sacrifices of the soldiers and sailors that fashioned our country. VA owns almost 2,000 historic structures. Many are suffering from neglect and deteriorate further every year. These structures must be stabilized, preserved, and protected. The first step in addressing this important legal and moral responsibility is for VA to develop a comprehensive national program for its historic properties. Because the majority of these structures are not suitable for modern patient care, the current CARES planning process will *not* produce a national strategy for the preservation of historic properties. A separate initiative must be undertaken immediately.

VA must inventory its historic structures and establish broad classifications regarding their current physical condition and their potential for adaptive reuse. This reuse may be either by VA medical centers or by local governments, nonprofit organizations, or private-sector businesses. In order to accomplish these initial objectives, we recommend that VA establish partnerships with other Federal departments, such as the Department of the Interior, and with private organizations, such as the National Trust for Historic Preservation. This expertise should prove helpful in establishing this program. In addition, VA must expand its current staffing for this new task.

In conjunction with an adaptive reuse program, VA needs to develop legal models and strict administrative policies for protecting those historic structures that are leased or sold. VA's responsibilities, for example, could be addressed through legal easements on appropriate property elements, such as building exteriors, interiors, or grounds. The National Trust for Historic Preservation has successfully completed a cooperative agreement assisting the Department of Army with the management of its historic properties.

We propose a $25 million budget for FY 2005 in order to stabilize, preserve, and reuse the thousands of historic VA properties. The funds should also be used to maintain VA's artifacts and collections and to provide grants to local organizations for preservation activities related to veterans facilities. We support the proposed language in Section 8171 for the establishment of a fund and for its purpose.

The protection and preservation of VA's historic structures is an important responsibility that the Department has ignored for too long. Faced with scarce funding and competing patient care demands, VA management has delayed addressing this issue for decades. We therefore recommend that specific funding and detailed responsibilities are included in the FY 2004 budget for this purpose.

Recommendation:

Specific funds should be included in the FY 2005 budget to develop a comprehensive program for the preservation and protection of VA's inventory of historic properties.

STATEMENT OF
PETER S. GAYTAN, PRINCIPAL DEPUTY DIRECTOR
VETERANS AFFAIRS AND REHABILITATION DIVISION
THE AMERICAN LEGION
BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
ON
THE DEPARTMENT OF VETERANS AFFAIRS REAL PROPERTY AND FACILITIES MANAGEMENT IMPROVEMENT ACT OF 2004

JUNE 22, 2004

Mr. Chairman and Members of the Subcommittee:

Thank you for this opportunity to present The American Legion's view on the Department of Veterans Affairs Real Property and Facilities Management Improvement Act of 2004 being considered by the Subcommittee today. The American Legion commends the Subcommittee for holding a hearing to discuss this important legislation.

This bill would amend title 38, United States Code, to authorize the Secretary of Veterans Affairs to enter into certain capital leases, to authorize the Secretary to transfer real property subject to certain limitations, and for other purposes.

SEC. 2. Capital Leases
This provision authorizes the Secretary of Veterans Affairs to enter into leases for Community Based Outpatient Clinics (CBOCs) in seventeen different locations nationwide. This would be the first implementation of the Capital Asset Realignment for Enhanced Services (CARE) decision.

The American Legion has long supported the development of CBOCs that meet established criteria as a means of improving veterans' access to health care. As VA attempts to improve accessibility to health care for veterans, the establishment of these facilities will help ensure that veterans receive the health care they have earned through their service. The American Legion is pleased to see that each of the CBOCs considered "priority" within the FY 2005 Budget Request are included in this legislation. The American Legion fully supports this provision's enhanced services.

SEC. 3. Department of Veterans Affairs Capital Asset Fund
8117. Authority for transfer of real property; Capital Asset Fund
This section authorizes the Secretary to transfer real property to another Department or Agency, State, or any public or private entity to include an Indian tribe and all funds received as a result of that transfer will be deposited in the newly established Department of Veterans Affairs Capital Asset Fund.

This section would also eliminate the Nursing Home Revolving Fund as outlined in the Administration's FY 2005 VA Budget Request. The Nursing Home Revolving Fund currently provides for construction, alteration, and acquisition of nursing home facilities and may be used only as provided for in appropriations acts.

The American Legion does not support the elimination of the Nursing Home Revolving Fund. Currently, the funds contained in the Nursing Home Revolving Fund are specifically targeted to construct new nursing home facilities and improve existing long-term care services. Creating the Capital Asset Revolving Fund without earmarking funds for long-term care facilities may have a detrimental effect to the quality and accessibility of long-term care within VA. While The American Legion agrees with the purposes for which the Capital Asset Revolving Fund would be expended, it is extremely important that funds are specifically allocated for VA to meet the long-term care requirements mandated in the Millennium Health Care Bill.

Additionally, The American Legion is concerned that any funds received from the transfer of real property would be significantly reduced once the cost of demolition, environmental cleanup, maintenance and repair, improvements to facilitate transfer, and any other costs associated with Federal requirements are met. It should not cost the VA more to transfer a property than the true value of the property. The new owner or Federal agency should absorb those additional costs.

(e) Procedures Applicable To Transfers
This section establishes procedures that the Secretary of Veterans Affairs must comply with in the transfer of any real property.

The American Legion supports the requirement to hold public hearings to allow stakeholders to comment on the impact of any proposed sale of VA properties. Since the beginning of the CARES process, The American Legion has stressed the importance of veterans' community involvement in any proposals affecting VA facilities.

(f) Contingent Effectiveness
This section requires the Secretary to submit to Congress an update on VA's compliance with subsection (b) of Section 1710B of Title 38.

The American Legion supports any additional congressional oversight that ensures VA meets the mandates outlined in the Millennium Health Care Bill.

SEC. 4. Authority to use project funds to construct or relocate surface parking incidental to a construction or non-recurring maintenance project.
This authorizes the use of construction or non-recurring maintenance funds to construct or relocate surface parking lots incidental to the projects. In its visits to numerous VA healthcare facilities, The American Legion notes that the current moratorium on new parking space has resulted in congestion and inconvenience to veterans, families and employees. In some instances, facilities have resorted to contracting valet parking services to address the short-term problem. The American Legion supports measures that will create greater ease of access to VHA facilities.

SEC. 7. Extension of authority to provide care under long-term care pilot program.
This section extends the long-term care pilot program as mandated in the Millennium Health Care Bill.

The American Legion has long been a strong supporter of long-term care within VA for eligible veterans. Any language extending the pilot program should state that the Secretary "shall continue to provide" services provided under the pilot program as opposed to "may continue to provide" services. Once VA assumes the responsibility to provide long-term care for a veteran, that obligation should not be subjective, but rather a commitment.

Mr. Chairman, that concludes my testimony. Again, I thank the Subcommittee for this opportunity to present testimony. The American Legion looks forward to working with each of you on these important issues.

Heritage Guard Preservation Society, Inc.[2]
115 West Main Street, 2nd Floor
Madison, WI 53703
Tel: (608) 255-8678 Fax: (608) 255-2715

"preserving--so we don't forget"

June 24, 2004

Rep. Rob Simmons, Chairman of Subcommittee on Health
Veterans Affairs Committee
United States House of Representatives
c/o John Bradley

Re: Written Testimony for June 24 Hearing on Bill Draft (via fax and mail)

Dear Chairman Simmons:

Thank you for including our testimony concerning the Subcommittee on Health's discussion draft of the amendments to Title 38, United States Code, which include amendments to authorize the Secretary of Veterans Affairs to enter into certain capital leases and to transfer real property. We ask that the subcommittee consider the following in its development of a final draft of this new bill.

Please note that we have submitted this testimony via email and fax today so that it may be part of the June 24, 2004, hearing. We are further sending an express mail package, which contains this testimony along with the enclosure cited below, to arrive within five days of the June 24th hearing. Please accept for the record all of these comments as being relevant for the House subcommittee's review.

OUR COMMENTS

To improve and strengthen the bill, as it is currently drafted (F:/V8/061804/061804.208), we offer the following recommendations:

I. **Emphasize historic value; require preservation and maintenance.** Though Section 3 stipulates that funds be set aside to preserve any structure which is on the National Register of Historic Places, and/or National Register eligible, the draft does not mandate that the Department of Veterans Affairs require the preservation and/or restoration of its many historic and historically significant buildings as part of any capital leases and/or transfers of real property. This is especially disturbing since a long-time lack of maintenance and restoration of historic buildings has led to increased maintenance costs and even demolition by neglect at many Department of Veterans Affairs sites, including its most historic locations[1]. Today, the Department of Veterans Affairs is facing a need to gather capital revenue through leases and property transfers, in part, because of decades of structural neglect.

By not securing, in this bill, a Department of Veterans Affairs promise to safeguard the historic value of the very buildings and grounds it seeks to gain commercial and veteran benefits from, the subcommittee would further demolish the legacy of freedom that the Department of Veterans Affairs' veteran residents and patients have left behind for future generations to remember.

We encourage the subcommittee to again consider the wording submitted June 8, 2004, by the National Trust for Historic Preservation, which reads:

> "If a property is listed or eligible for listing on the National Register of Historic Places or if Sections 106 or 111 of the National Historic Preservation Act apply, then the Veterans Administration shall ensure that the requirements of the National Historic Preservation Act and its implementing regulations are fully satisfied."

II. Require a Preservation Conveyance. We further encourage the subcommittee to define a "preservation conveyance" as a restricted conveyance whereby historic preservation is the first and foremost purpose of any property transfer. We believe that this serves both the Department of Veterans Affairs and its veterans simply by preserving their legacy, often the most important and primary desire of a veteran. A restricted conveyance should be made available to both public and private interests whereby interests that desire to preserve the heritage of veterans or the Department of Veterans Affairs are given every opportunity or advantage to be able to raise the required funding. For example, properties subject to a restricted conveyance may qualify for tax credits, subject to appropriate restrictions.

III. Eliminate Market Rate and/or Fair Market Value Requirements. We encourage the subcommittee to consider modifying or eliminating the requirement for the Department of Veterans Affairs to lease or transfer real property at "fair market value" since there are times when fair market value restrictions make developing, restoring and/or preserving historic buildings cost prohibitive and may, in fact, prevent the Department of Veterans Affairs from realizing the most viable solutions for the department, veterans and the community. As stated earlier, property subject to a "preservation conveyance" could be legitimately transferred at below market value in order to accomplish the preservation objective of the property transfer.

IV. Clarify "grant and per diem providers". We ask the subcommittee also further define the terms "grant and per diem providers" and more specifically outline the circumstances involved in a transfer to such providers.

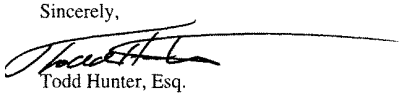
CONCLUSION

What is evident today is that so much American history is contained within the bricks and mortars standing on Department of Veterans Affairs properties throughout the United States of America. This bill offers America and the Department of Veterans Affairs the opportunity to safeguard the history of freedom, a history preserved by the veterans who recuperated, lived and died at federal disabled veteran facilities (now VA Medical Centers) since the end of the Civil War[1]. As Indian nations honor their burial grounds, we hope that this bill will strive to honor all of our veterans, including the facilities in which they sought refuge and rehabilitation.

We believe that we can make a valuable contribution to the subcommittee's efforts to resolve these issues. As the significance of Department of Veterans Affairs property is becoming more widely appreciated, we believe that our contributions could help the subcommittee develop language to satisfy the needs of the Department of Veterans Affairs, and its deteriorating historically significant properties, as well as the national requirement to preserve our heritage and honor those who have preserved our freedom.

To that end, we are requesting an appointment with Congressman Simmons to specifically discuss the enhanced used lease and property transfer processes for historic preservation. By this, we seek to inform him of current preservation objectives as well as of the kind of public/private partnerships (such as the *American Patriot Preserve* example enclosed) that not only preserve the Department of Veterans Affairs properties in question throughout the country but also produce potential revenue for Department of Veterans Affairs services.

Sincerely,



Todd Hunter, Esq.
& Kristin Gilpatrick Halverson
The Heritage Guard Preservation Society, Inc.[2]

Enclosures (coming via express mail)

- Proposal to President George W. Bush: *The American Patriot Preserve*

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[1] Among the most historically significant Department of Veterans Affairs sites, currently being considered for commercial development via enhanced use lease programs, are two of the three original federal homes for disabled veterans founded by President Abraham Lincoln in 1865, including the 1869 Milwaukee Soldiers Home (originally known as the National Home for Disabled Volunteer Soldiers) and its 25-building historic district on the grounds of the Clement J. Zablocki VA Medical Center in Milwaukee, Wis. Founding the federal veterans homes and hospitals as places for war veteran care and recuperation —at the urging of Milwaukee women's groups and the widow of a Wisconsin Civil War governor—was one of President Lincoln's final acts prior to his assassination.

[2] The Heritage Guard Preservation Society, Inc., is a non-profit 501(c)3 corporation whose mission is to preserve the significant history of American veterans and acknowledge their contributions and sacrifices made in the quest to preserve peace and freedom. Its current focus is the preservation of the Milwaukee Soldiers Home Historic District, on the grounds of the Clement J. Zablocki VA Medical Center in Milwaukee, Wis. (For an outline of our developing vision – an example of the kind of place and partnership that VA facilities can become – see the *American Patriot Preserve* enclosure.) Additionally, we have been in contact with Department of Veterans Affairs employees, as well as citizens and preservationists, in Ohio, Virginia, Washington, D.C. and Los Angeles to further development of freedom and heritage tourism centered in Milwaukee and other VA sites across the United States.